Maternal and Child Health Services
Title V Block Grant

State Narrative for Montana

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Montana Department of Public Health and Human Services complies with all required assurances and certifications for federal grants. Copies of the required documents may be accessed through the Director's Office at http://www.dphhs.mt.gov/directorsoffice/.

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The Family and Community Health Bureau (FCHB) is the designated Title V Agency for Montana. The Bureau's goal for the 2010 needs assessment and the 2011 MCH Block Grant Application and 2009 Annual Report was to ensure active, public input and partner involvement in the planning of those documents and reports.

The Family Health Advisory Council was not reappointed by the Governor in 2009, due in part to an effort to decrease the number of advisory groups. Instead, the Public Health System Improvement (PHSI) Task Force, a group already charged with overseeing and providing input to Montana's Preventive Health and Health Services Block Grant was selected to provide public input. The PHSI was established in 1993 with the purpose of advocating for statewide public health improvement efforts. Its membership includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties) and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service. Additional information about the PHSI Task Force is included as an attachment.

In order for the MCH Needs Assessment process to be effective, the needs assessment participants were briefed on the yearly MCH Block Grant Application and Annual Report contents.

As mentioned elsewhere in this document, i.e. II. Needs Assessment, C. Needs Assessment Summary and in more detail in the 2010 Montana Maternal and Child Health Needs Assessment document, there were numerous venues for public input. Over the course of developing the 2010 Montana Maternal and Child Health Needs Assessment, 226 health care professionals; 115 MCH partner organizations; 40 key informant interviewees; and 49 parents who had children with special health care needs, 53 adolescents, and 49 parents of children aged 0 to 12 years through their participation in Focus Group discussions held in four communities and one American Indian Reservation. All of these individuals were enlightened on the MCH Block Grant Application and Annual Report.

The 2010 MCH Needs Assessment and the 2011 MCH Block Grant Application and 2009 Annual Report will be posted on the FCHB's webpage after July 15, 2010. At that time, the PHSI Task Force members and the interested parties will be sent information electronically about the documents' posting and they will be invited to offer their comments on these documents. To simplify this process, the FCHB has created a separate email account HHS MCH BlockGrant@mt.gov, for comments that will be shared with the FCHB and the PHSI Task Force. These comments will also be used, when applicable, on future MCH Block Grant applications.

The FCHB will continue to solicit input on the yearly application through the Pre-Contract Survey, which is contractually required of the health departments accepting MCH Block Grant funding. Additionally, the PHSI Task Force which meets regularly will be kept apprised of the MCH Block Grant Application and Annual Report.

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The 2011 MCH Block Grant Application and 2009 Annual Report were posted on the FCHB webpage and partners, i.e. local health departments, state and community based agencies were informed of their opportunity to provide comments using the email account HHS MCH BlockGrant@mt.gov. No comments were received using this method.

At each of the six Montana regional Maternal and Child Health Meetings, co-sponsored using SSDI and MCH BG funding, comments were received on the 2011 MCH Block Grant Application and 2009 Annual Report. Attendees were queried on nine topic areas that were covered by the MCHC Section Supervisor and Lead FCHB Epidemiologist and on future topical areas. The results are included on the attached 2010 MCH Regional Meetings Evaluation Summary. The MCHC and Epi Units anticipate offering Regional Meetings the fall of 2011. See the attachment: Public Input Evaluation Summary.

The PHSI Task Force membership was being reappointed at the time of the July 2011 submission. The PHSI Task Force will have an opportunity to review the August 2011 comments and offer input prior to the September 2011 final submission. The final PHSI Task Force reappointments were not completed by the 9/14/2011 final submission date.

A CSHS parent representative reviewed the CSHS 2012 MCH Block Grant performance measures Because this was her first opportunity to do so, most of her feedback was seeking clarification about the grant application process and ability to follow the material given the TVIS character limits. Additionally she provided feedback about opportunities to conduct additional surveys and projects with additional resources in the CSHS program. Based on parent feedback, CSHS will propose to the CSHS Advisory Committee to allot time at the next meeting to review the CSHS performance measures of the 2013 MCH Block Grant Application.

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The need for increased public input has been an ongoing discussion. The final 2012 Application/2010 Annual Report was posted on the FCHB webpage and MCH BG partners were notified of the opportunity to provide comments. The response rate was less than ten comments; therefore, the MCHC Health Education Specialist was charged with the task to develop a Public Input Plan with a goal of increasing public comment. The MCHC Health Education Specialist researched other states' public input methods and developed a draft MT Public Input Plan that is currently being reviewed for adaption. See the attachment.

The Pre-contract Survey remains as an avenue for local public health departments' to provide input on the MCH Block Grant. Additionally, it provides information to the MCHC Section within the FCHB, which is the administrative MCH BG entity, on areas of quality improvement and health department requests for technical assistance.

CSHS reviewed related state and national performance measures from the MCH grant with the Children's Special Health Services Advisory Committee in November of 2011. The committee members and guests included parents, specialists, administration and audiologist from the Montana School for the Deaf and the Blind, regional pediatric specialty clinic nurses and social workers, pediatricians, and Montana Family Voices (PLUK) staff. As is state policy, these meetings are published on the State of Montana and DPPHS public calendars and are open to the public.

CSHS continues to solicit parent, provider and public input regarding program activities. On June 27, 2012 CSHS held a public hearing regarding an Administrative Rule Amendment. The amendment was sent to an interested parties list of over 100 people/agencies. This amendment was primarily to increase the financial assistance opportunity for CYSHCN and their families to 250% FPL (from 200% FPL).

Beginning in January 2010, the management team for the Public Health and Safety Division (PHSD) conducted four meetings to review the draft version of the Public Health Accreditation Board (PHAB) Standards and Measures, and begin discussing the steps that would be taken to become an accredited State Health Department. That review process led to the establishment of a Core Team of staff within the Division to collect existing documentation and begin an analysis of where the organization was at, in relation to meeting the standards. In September of 2011, all existing documentation had been gathered and the final version of the PHAB standards was released.

The PHSD has been working to put systems in place that not only meet the PHAB standards for an accredited health department, but improve the overall function and performance of the agency. As part of a fully integrated management system, the Division is implementing systems for performance management, workforce development, agency strategic planning and State Health Improvement Planning. The goal of the agency is to apply for Accreditation in 2013.

A key accreditation activity is developing the Montana State Health Improvement Plan, which includes the following state health improvement goal areas: 1) Prevent, Identify, & Manage Chronic Conditions; 2) Prevent & Control Communicable Disease; 3) Promote Maternal & Child Health; 4) Reduce Tobacco Use; 5) Increase Immunizations; 6) Reduce Injuries & Environmental Health Hazards; and 7) Promote Physical Activity & Health Eating.

The Montana Public Health System Improvement Task Force (PHSITF) will serve as the Steering Committee for the Montana State Health Improvement Plan. The Task Force consists of four Health Officers representing Large, Medium, Small and Frontier counties, seven agencies/statewide partnering organizations, including Tribal Health and two ad hoc members; one from the PHSD and one from the MT Department of Environmental Quality.

The PHSITF members and FCHB Section Supervisors and Bureau Chief, have been asked to use their experience, expertise and insight to help build a plan that includes health and system improvement goals. Members have specifically been asked to advocate for the purpose and direction of the plan, bring ideas and solicit input from stakeholders, engage in workgroup activities, attend planning meetings, recommend final goals, strategies and objectives of the State Health Improvement Plan and facilitate the plan throughout the state. The State Health Improvement Plan, as well as the input from the PHSITF members, will be a valuable resource for future public input and the 2015 MCH BG Needs Assessment.

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An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Family and Community Health Bureau (FCHB) regards the needs assessment process as an ongoing, bureau-wide activity due to the interest and involvement of state and local partners -- particularly those who contract for MCHBG finding -- in improving MCH in Montana. To continue to build on the 2005 Needs Assessment, an existing Bureau team with membership from all programs in the Bureau was expanded and became the Needs Assessment Team that developed a process for the 2010 needs assessment.

A statewide preliminary planning survey was conducted in the summer of 2008 with MCH partners to solicit feedback regarding previous methodologies, data gaps, and representation. This survey resulted in an initial list of priority needs and recommendations for conducting the needs assessment and an overall suggestion for enhanced public input, greater partner involvement at the state and county level, and a systematic approach to identifying problems and possible solutions.

Montana's needs assessment process included focus groups with priority populations, surveys of public health professionals, and interviews with key informants who had MCH experience. The focus group populations were determined based on a review of data sources. Priority populations were selected, in part, to augment assessment for populations with limited data, including adolescents and parents of Children and Youth with Special Health Care Needs (CYSHCN). A survey of public health professionals, which was conducted in the summer of 2009, identified local organizations serving the MCH population in Montana. Key informant interviews provided in depth data from partners who worked in either a public or private MCH related organization.

The qualitative and quantitative data collected by the FCHB, was presented to the Public Health System Improvement (PHSI) Task Force in Winter/Spring 2010. The PHSI Task Force membership includes representatives of local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service. The Task Force was charged by the Division administrator with the responsibility to assist staff to finalize Montana's 2010-2015 list of MCH priority areas and performance measures.

During the previous needs assessment process, priority areas were developed independent of the performance measures. While all but one of the previous priority areas related to at least one state and national performance measure, they were more directly correlated with objectives in the Bureau's strategic plan. For the 2010 needs assessment process, priority areas were identified simultaneously with performance measures, and the relationship of those priorities to the Bureau and Division strategic plans was also considered. Only areas with an identified measure that were relevant at the state and/or local level were chosen. The 2010 -- 2015 MCH priority areas include: child safety/unintentional injury; access to care, with a focus on children with a special health care need, i.e. cleft lip and/or palate; preconception health; smoking during pregnancy; oral health; Montana's Varicella immunization requirement; and Montana's Diptheria, Tetanus, and Pertussiss immunization requirement.

The next step is the creation of action plans for the priority areas and related state performance measures through a cooperative activity between the state and local contractors. The MCH contracting process requires that local contractors complete a "pre-contract survey" in the spring

of each year, indicating the state or federal performance measure that local efforts will focus on during the contract period. Local contractors are also required to describe evidenced based activities they will employ to address the selected measure. In FFY 2010, local contractors are being asked to provide their selected activities as short, open ended answers on the surveys -- state staff will compile and categorize those responses by level of the pyramid in anticipation of the FFY 2011 pre-contract survey. State staff will research all proposed activities to find sound scientific evidence to support action plans being prepared at the state level. This participatory process allows locals to contribute to the development of action plans for performance measures.

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The 2010 -- 2015 MCH priority areas remained the same. The creation of the Office of Epidemiology and Scientific Support within the PHSD, has resulted in State Performance Measure 3 being revised to better reflect the state's capacity to implement activities and collect data.

Needs Assessment Topic Specific Summaries were created from the 2010 MCH Needs Assessment document and are available at: http://www.dphhs.mt.gov/PHSD/family-health/mchc/phsd-mch-assessment.shtml

The 2012 Pre-Contract Survey required each health department to develop a SY 2012 Operational Plan for their selected NPM or SPM. The MCHC Health Education Specialist will be working with and providing feedback to the health departments throughout the year on their respective Operational Plans. The 2012 PCS format will be used in subsequent years with the intent to incorporate the results into the 2015 MCH BG Needs Assessment. See the PCS attachment.

In 2011, the Primary Care Office (PCO) collected data on the state's practicing medical, dental, and mental healthcare providers which will be used in the 2015 Needs Assessment. The PCO anticipates ongoing updates of this data as funding allows.

CSHS is preparing to apply for the 2012 State Implementation grant by conducting a comprehensive CYSHCN needs assessment by December 2011. The CSHS results will be incorporated into the 2015 MCH Needs Assessment.

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A number of data collection efforts were undertaken and data collection plans were developed by several FCHB sections in the last year. It is anticipated that this data, as well as the work being done on Montana's Health Improvement Plan, will be incorporated into the 2015 Needs Assessment document. Refer to the Public Input section for details about Montana's Health Improvement Plan.

In the fall of 2011, CSHS conducted a telephone survey of the adults and children that have attended a Cystic Fibrosis Clinic. The purpose of this survey was to determine access to and general satisfaction with the quarterly Cystic Fibrosis Clinics. The survey responses led to the development of a quality improvement plan. See Cystic Fibrosis Survey in NPM 2.

In November of 2011 CSHS conducted a Needs Assessment, which included Montana and national data to determine the principal needs for Montana's CYSHCN and their families. The Needs Assessment results indicated two areas: 1) Access to primary and specialty care; and, 2) Effective care coordination. The results were used for the State Implementation grant application, which is described in greater detail in the Other MCH

Capacity section. See attached survey.

The WIC Program is working with the OESS to determine "Montana WIC Estimated Eligible Participation." The focus of the project is to enable state and local agency staff to collaboratively narrow the gap between the number of eligible people and the number of clients who actually participate in the WIC program. The project's methodology model is based on the following criteria: Poverty level, births and children population counts and estimates, adjunctive eligibility, adjunctive monthly versus yearly income and WIC participation. The model projects the estimated number and percent of WIC eligible people and estimates for each county by WIC category (infants, children, pregnant, postpartum and breastfeeding).

The WMHS conducts annual community participation surveys with local Title X DA. Each agency collects 30 client surveys that review the top health priorities of the community, review how each person heard about the clinic, what type of marketing is best for the audience, and some demographic information. The DA chooses one of the top health priorities and develops a goal, objective, and activities to meet the goal. WMHS reviews each DA's plan semi-annually and provides educational resources and toolkits to help with their activities.

WMHS conducted a SY 2012 satisfaction survey to learn more about the needs of Title X delegate agencies and how WMHS can help in meeting their needs. WMHS also conducted four male focus groups to learn more about the needs of men regarding reproductive and sexual health care. The focus groups included questions on marketing, resources, and general health care concerns.

The 2013 Pre-Contract Survey county information was used to create a MCH BG Operational Plan for each county accepting the 2013 MCH BG funds. The Operational Plan is based on the SMART (Specific, Measureable, Attainable, Realistic, & Timely) goal setting method. The MCHC Supervisor and MCH BG Program Specialist review and provide feedback on the Plan and also share the plan with appropriate agency partners. The goal is to assist the County with achieving their goal to improve their 2013 NPM or SPM. Additional information is included in the Health Systems Capacity Indicators' section.

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An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

PROCESS TO ESTABLISH TITLE V NEEDS AND PRIORITIES:

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The Title V Program functions within the Family and Community Health Bureau (FCHB) in the Public Health and Safety Division (PHSD) of Department of Public Health and Human Services (DPHHS). The Title V activities support Montana's MCH population issues and needs. Bureau activities include reviewing epidemiological data and information from stakeholder and public input activities, ensuring state and local staff are adequately trained in MCH program and policy development, development and implementation of evidence based programs and services addressing the health needs and risks impacting the MCH population, partnering to develop client services data systems and quality assurance for service delivery, and communicating regularly to manage the Title V Program at both the operational and population health levels.

During FY2009, in preparation for the Maternal and Child Health Block Grant (MCH BG) application, Montana conducted an assessment of the health needs of women, infants, children, adolescents, and children with special health care needs in the state. The assessment consisted of various components including a review of subjective and objective data with state and local parties to ensure coordination of services. The assessment consisted of consumer input through focus groups, key stakeholder interviews, and professional judgment from those working in the field. The needs assessment process and resulting priority areas are more fully described in other sections and in the 2010 MCH Needs Assessment document, which is included with the 2011 application. The 2010 MCH Needs Assessment is a valuable tool for guiding the state's current and future MCH Block Grant applications.

Montana utilizes the Public Health System Improvement Taskforce (PHSI TF) as the advisory group which assists state staff to examine data and develop plans. The PHSI TF was created in 1993 and is responsible for implementing a statewide strategic plan for public health, developing policy recommendations and advocating for public health (PHSI TF Charter). The PHSI TF also serves as advisory for the preventive health block grant.

The FCHB's role in addressing these priority areas is through the major functions of public health, which are assessment, policy development and assurance. The Bureau may serve primarily to inform partners about the issue (assessment), may establish programs and services to address particular issues (policy development), and/or may work with public and private partners to facilitate access for the MCH population to needed services (assurance).

INTRODUCTION: Montana's geography, nature of her minority groups, political jurisdictions, economic characteristics, population size and distribution have a profound effect on the health of her citizens, how direct and public health services are provided, and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and 7 Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and has several state parks and state forest areas. The eastern two-thirds of the state are semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches.

ENVIRONMENTAL CONCERNS: Montana's environmental history includes extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues.

However, these extraction processes have left a legacy of environmental pollution. In 2010, Montana had 15 Federal Super Fund sites and 209 Comprehensive Environmental Cleanup Responsibility Act (CECRA) priority facilities . The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana Department of Public Health and Human Services (DPHHS) has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the Environmental Protection Agency (EPA) in 2010, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

POPULATION CHARACTERISTICS: The U.S. Census reports the 2009 population estimate to be 974,989, 44th in terms of population, with a population density of 6.6 people per square mile. The 2009 population estimates for Montana suggest an overall increase of 8.1% from 2000. The instate population has been redistributing to the western portion of the state and into urban areas over the last decade. The 2008 estimate projects that Montana has six counties with a population over 50,000 people and that 59% of Montanans reside in these six counties. The remainder of the population is dispersed into smaller communities, farms, and ranches . In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2009. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Anticipated population for 2030 is 1,044,898, ranking 27th in the nation for population growth .

AMERICAN INDIAN POPULATION: According to the 2008 Census estimate, there were 62,399 self-identified American Indians in Montana, or about 6.4 percent of the total population. Approximately 37,871 American Indians, or about 57.4 percent, lived on one of the state's seven reservations. The Blackfeet and the Flathead reservations were the largest, with 8,665 and 7,853 American Indian residents, respectively. Rocky Boy's (2,598) and the Fort Belknap (2,805) reservations were the smallest.

AGE: The median age in Montana for 2006-2008 was 39.3 years, higher than the national average of 36.7 years. 6.3% of the Montana population was under 5 years of age and 23% was under 18 years of age, compared to 6.9% and 24.5 % of the US population. Montana's population is split evenly between males and females. According to 2009 U.S. Census Bureau Estimates, women of reproductive age (15-44 years) comprise 17% of the state population .

ACADEMICS: Montana's graduation rate for public high school students for the 2005-2006 school year was 82% compared to the national average of 73%.

Mathematics, Grade 8--the percentage of students in Montana who performed at or above the National Assessment of Educational Progress (NAEP) Proficient level was 44 percent in 2009. This percentage was greater than that in 2007 (38 percent) and was greater than that in 1990 (27 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 82 percent in 2009. This percentage was greater than that in 2007 (79 percent) and was greater than that in 1990 (74 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of poverty, had an average score that was 22 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1996 (24 points). In 2009, the average mathematics score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 44 states/jurisdictions
- not significantly different from those in 5 states/jurisdictions

Reading, Grade 8-- The percentage of students in Montana who performed at or above the NAEP Proficient level was 38 percent in 2009. This percentage was not significantly different from that in

2007 (39 percent) and was not significantly different from that in 1998 (40 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 84 percent in 2009. This percentage was not significantly different from that in 2007 (85 percent) and was not significantly different from that in 1998 (83 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of low income, had an average score that was 14 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1998 (17 points). In 2009, the average score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 39 states/jurisdictions
- not significantly different from those in 10 states/jurisdictions

ETHNICITIES: Montana is predominately white with an estimated 90.5% of the 2008 population reporting Caucasian as the primary race, compared to 79.8% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.4% of the total population (62,399), the 5th highest state in the nation.

Census Population		2000	2009 Estimate
White	90.6%		90.5%
Black	0.1%	0.7%	
American Indian		6.2%	6.4%
Asian	0.5%	0.6%	
Native Hawaiian/			
Other Pacific Islander		0.1%	
Two or more races			1.7%
Other	0.6%		

BIRTH & FERTILITY RATES: The Montana birth rate declined from the early 1980s to 1999. The rate of births to Montana residents leveled off and has increased in recent years. It grew to 13.2 per 1,000 residents in 2006 and fell just a bit in 2007 and 2008 to 13.0 . As with many small population states, Montana's health indicators may change dramatically from year to year, leading the public and sometimes policy makers to assume associations between programs and activities and outcomes. In fact, what may appear to be dramatic changes, such as a child death rate dropping to 25 per 100,000 children aged 1-14 in 2005, down from a rate of 33 in 2000, may be due to very small changes in actual numbers.

In 2008, the fertility rate for Montana's white mothers of all ages was 66.2, the birth rate for white mothers between the ages of 15 and 17 was 14.5, and the rate for white mothers between the ages of 18 and 19 was 62.4. Fertility rates for Native Americans were substantially higher in these age groups--107.8, 55.1, and 188.3, respectively. American Indians account for about 6.4% of the total Montana population, and more than 12% of births.

Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites.

INDIAN HEALTH SERVICES, TRIBAL HEALTH ENTITIES & POLITICAL JURISDICTIONS: According to the U.S. Census Bureau designations, the state has 3 metropolitan areas (an urban population core of 50,000 or more) and 5 micropolitan areas (an urban population core of 10,000-49,999). However, the majority of the 56 counties are still considered rural or frontier. Fifty-four county health departments contracted with the DPHHS in FY 2010 to provide Maternal and Child Health (MCH) and other health services. The local health departments are county entities under the control of local Boards of Health and the staff are county employees. The seven Indian reservations are sovereign nations and home to 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems.

INDIAN RESERVATIONS and COORDINATION OF SERVICES: The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a continuing goal to increase the number of partnering reservations.

ECONOMIC ENVIRONMENT

MONTANA WAGES: Among the states with annual pay below the U.S. average, Montana posted the second lowest average pay ($33,305) in 2008. The lowest pay level was in South Dakota ($32,822). The next lowest pay levels were Mississippi ($33,508), Idaho ($33,897) and Arkansas ($34,919). The 2008 average annual pay figures for these states, which account for only 2.8 percent of the nation's workers, were 25 to 28 percent below the national average. Average annual pay levels for 36 states were below the U.S. average in 2008; combined, workers in these states accounted for 52 percent of the nation's covered employment .

FEDERAL AID: Montana taxpayers receive more federal funding per dollar of federal taxes paid compared to the average state. Per dollar of federal tax collected in 2005, Montana citizens received approximately $1.47 in the way of federal spending. This ranks the state 11th highest nationally and represents a rise from 1995 when Montana received $1.46 per dollar of taxes in federal spending (6th highest nationally). Resources supporting state level efforts for the MCH population, including Children & Youth with Special Healthcare Needs (CYSHCN), are overwhelmingly federal. Less than 5% of funding for the Public Health and Safety Division (PHSD), which houses the FCHB, is from the state general fund.

POVERTY: According to the U.S. Census Bureau's Current Population Survey, Montana's estimated poverty rate was 14.1% in 2007, which was above the national estimated poverty rate of 13.3%. Montana had the 16th highest poverty rate in the U.S. in 2007. From 2002 to 2007, Montana's poverty rate varied from a low of 13.6% in 2004 to a high of 14.6% in 2005. The percentage of near poor, those with incomes below 125%, 150% and 200% of the Federal poverty level, was higher in Montana than nationally. Montana counties reporting the highest poverty rates in 2007 include Roosevelt (30.3%), Glacier (26.6%) and Big Horn (26.4%). These three counties had poverty rates that were over 26%, with Roosevelt's rate (30.3%) being over twice as high as the state average (14.1%). Of the 56 counties in Montana, 36 of them held poverty rates above the national average of 13% in 2007. The lowest poverty rates were reported by Fallon (9.3%), Sweet Grass (9.4%) and Yellowstone (9.7%) Counties in 2007.

In 2007, about 15.7% of children under 18 years of age lived below the poverty line in Montana, while about 18% of the same age group lived below the poverty line in the U.S. About 13.2% of Montanans age 18 to 64 lived below the poverty line in 2007, while about 10.9% of this age group lived below the poverty line in the U.S. While 6.7% of individuals age 65 and over lived below the poverty line in Montana, about 9.7% of individuals age 65 and over lived below the poverty line in the U.S. in 2007.

AMERICAN INDIAN ECONOMIC CHARACTERISTICS: Health care and social assistance are the primary employers of American Indians in Montana. These two industries employ about 3,353 American Indians statewide. Public administration (which includes all forms of government) and educational services were second and third, employing 3,200 and 2,660 respectively. The median household income for American Indians was $22,824, far less than the $33,024 reported for all Montanan households. The median household income on the Crow Reservation was $28,199, compared to the $18,484 reported on the Fort Peck Reservation. A closer look at the figures reveals that the Crow Reservation reported by far the lowest percentage in the less than $10,000 income category. Furthermore, there were relatively more households on the Crow Reservation in the middle-income categories from $30,000 to $99,000. These households may

include people with relatively good-paying mining and Bureau of Indian Affairs (BIA) hospital jobs.

UNEMPLOYMENT: In 2009, Montana's unemployment rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2009 was 6.2%, compared to the U.S. rate of 9.3% . Unemployment on the reservations ranged from 8.5% to 16.3%, according to the 2009 Montana Reservation Labor Force Statistics. Data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

AMERICAN INDIAN UNEMPLOYMENT: Annual Average Unemployment Rates on Montana's Reservations

Reservations	2009
Blackfeet	13.8%
Crow	10.5%
Flathead	8.5%
Fort Belknap	Unavailable
Fort Peck	8.8%
Northern Cheyenne	14.0%
Rocky Boy's	16.3%

FACTORS IMPACTING THE MCH POPULATION

ORAL HEALTH: Eleven Montana Community Health Centers (Billings, Bozeman, Bullhook, Butte, Cutbank, Great Falls, Helena, Kalispell, Livingston, Missoula and Libby) include some dental services, though the waiting lists can be long.

Indian Health Service offers dental clinics in:

Browning (Blackfeet Service Unit [SU])	satellite in Heart Butte
Crow Agency (Crow SU)	satellites in Lodge Grass & Pryor
Lame Deer (Northern Cheyenne SU)	
Harlem (Fort Belknap SU)	satellite in Hayes
Poplar (Fort Peck SU)	satellite in Wolf Point
Tribal Programs:	
Box Elder (Rocky Boy SU)	
Polson (Flathead SU)	satellites in Pablo & St. Ignatius

Montana's point-in-time Pregnancy Risk Assessment Monitoring System (PRAMS) in 2002 reiterated lack of access to dental care for pregnant Medicaid participants as a statewide problem. In 2009, 11 counties did not have a dentist and 15 (including the 11) did not have a dentist that accepted Medicaid. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

IMMUNIZATIONS: In 2008, Montana had a 66% immunization rate for children aged 19-35 months who were fully immunized. In 2008, Montana ranked 50th in the nation for series of immunizations given to 19-35 month old children.

MORTALITY: (Rankings: 1=low, 51=high)
High mortality rates are a problem for Montana.

Infant Mortality
2004-2006: 6.0 per 1,000 live births

Death Rate for children aged 1-14 years
2006: 772.9 per 100,000

Five leading causes of death for MT children aged 1-14 years (2006):
1. unintentional injury (32.7%)
2. malignant neoplasms (14.3%)
3. homicide (6.1%)
4. congenital anomalies (4.1%)
5. suicide (4.1%), all others (38.8%)

Five leading causes of death for MT American Indian children aged 1-14 (2006):
1. unintentional injury (40%)
2. malignant neoplasms (20%)
3. suicide (20%)
4. all others (20%)
5. none listed

Death Rate for Total Population (all ages)
2006: 30 per 100,000

Five leading causes of death for total MT population (2006):
1. malignant neoplasms (22.9%)
2. heart disease (22.1%)
3. chronic low respiratory disease (6.8%)
4. unintentional injury (6.6%)
5. cerebrovascular (5.4%)
6. all others (36.1%)

Five leading causes of death for MT American Indian population--all ages (2006):
1. malignant neoplasms (19.9%)
2. heart disease (13.9)
3. unintentional injury (12.9%)
4. liver disease (6.1%)
5. diabetes mellitus (5.3%)
6. all others (41.8%)

In 2006, Montana had a suicide death rate of 19.7 per 100,000 in population.

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN): Montana had an estimated 27,853 children/youth with special health care needs in 2006, up somewhat from an estimated 26,981 in 2001. Examples of conditions that qualify children with special health needs in Montana are: cystic fibrosis, diabetes, cleft lip/palate, asthma, seizure disorder, and juvenile idiopathic arthritis. CYSHCN in Montana may be eligible to receive services from Children's Special Health Services (CSHS), DPHHS. The program's mission is to develop and support systems of care for CYSHCN. The following services are available to eligible CYSHCN and their families: pediatric specialty clinic services, financial assistance, and/or resource referrals. CSHS does not receive any general funds from the state of Montana, it is funded by the Maternal and Child Health Block Grant and revenue received from billing 26 health care agencies for three interdisciplinary clinics (cleft/craniofacial, metabolic and cystic fibrosis).

Effective January of 2008, all newborns are tested for hearing and the 28 conditions recommended by the American Academy of Pediatrics and the American College of Medical Genetics. The metabolic/bloodspot screen follow-up is a contracted service managed by CSHS. The newborn hearing screening program is managed by a staff member in CSHS. This staff person conducts on-site reviews for quality assurance and is continually assessing the needs of the families and partners of the newborn hearing program.

TOBACCO USE, MONTANA YOUTH:

In 2005, Montana introduced the Clean Indoor Air Act (CIAA) that was passed by the state legislature that required schools to be tobacco-free and public places to be smoke-free. The CIAA was fully implemented in October 1, 2009.
In 2009, 12% of high school youth who tried cigarettes before the age of 13, a 10% percentage point decrease from 2001 (29%). During 2009, the highest prevalence was reported for 9th grade students (18%) with the lowest prevalence reported for 12th grade students (8%) who tried cigarettes before the age of 13. Statewide, 50% of high school students had ever tried cigarette smoking (even one of two puffs) during 2009. The prevalence of high school youth who smoked cigarettes on at least one day during the past month decreased from 29% in 2001 to 19% in 2009. Cigarette use was more prevalent among females (20%) than males (18%) during 2009. The use of smokeless tobacco (e.g., chewing, sniffling, or dipping) among high school students decreased only slightly between from 16% in 2001 to 15% in 2009. In 2009, the use of smokeless tobacco was more prevalent among high school boys (24%) than high school girls (4%). In 2009, 55% of high school current smokers had tried to quit smoking cigarettes during the past 12 months.

In 2006, 38% of Montanans were aware that secondhand smoke is a risk factor for SIDS. In 2008, 97% of adults were aware that breathing secondhand tobacco smoke causes respiratory problems in children. Approximately 12% of Montana households with children permitted smoking at any time or any place in the home during 2008. In 2007, 30% of Montana children aged 12 to 17 years who lived in households where someone uses tobacco compared to 28% in 2003. Thirty-three percent of Montana high school students reported being in a car with someone who was smoking in 2008.

OBESITY: In 2007, 12% of Montana children aged 10-17 were obese compared to the national average of 16%. The obesity prevalence among Montana Youth increased over the past several years. The prevalence of obesity among Montana high school students increased significantly from 6% in 1999 to 10% in 2009. In 2009, high school girls had a lower prevalence of obesity (8%) compared to high school boys (13%). In 209, 24% of Montana adults were obese compared to the national average of 27%. The prevalence of obesity among Montana adults increased from 16% in 1999 to 24% in 2009. In 2009, females had a slightly lower prevalence of obesity (23%) compared to males (24%).

HEALTH CARE ACCESS
One Montana Critical Access Hospital CEO always began medical provider recruiting conversations with, "Our town is 70 miles from the nearest McDonald's, 90 miles from the nearest WalMart and 200 miles from the nearest shopping center. Can you handle that?" This description of an isolated Montana community is not unusual. A former Montana U.S. Senator put it this way, "There's a lot of dirt between light bulbs in Montana." Geographic isolation and the long distance between towns and healthcare organizations are often barriers to healthcare access in Montana.

Fifty-four percent of Montanans travel more than 5 miles (one way) to get to a doctor's office; 13% travel more than 30 miles; 7% travel more than 50 miles.

TRANSPORTATION: Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. With little or no public transportation available in Montana's many isolated, rural communities, access to local primary care as well as out-of-town specialty medical services can be a problem. Nearly 96% of Montanans drive themselves or get a ride from a friend when traveling to a doctor's office; fewer than 1% use public transportation (probably because public transportation is found primarily in urban areas and most of Montana is frontier or rural).

INCOME: Montana's lower-than-the-national-average median income adversely affects the

ability of many Montanans to pay for medical care. This is reflected in the 19.1% of Montana's population (nearly 180,000 people) without health insurance.

In a 2003 survey, 12.9% of Montana's adults reported they could not see a doctor in the previous 12 months because of the cost. Examining the survey a little closer, over a quarter (26.3%) of all Montana adults ages 18-64 with a disability--a population that probably needs to see a doctor regularly--had not seen a doctor in the previous 12 months because of cost. Also, over one-quarter (26.7%) of Montanans do not have a personal doctor or health care provider.

AVAILABILITY OF SERVICES: There are ongoing efforts towards the improvement of the availability of an access to health services in Montana. Montana has 45 Critical Access Hospitals, 17 hospitals, 46 rural health clinics, and 37 federally qualified health centers. There are also 56 local county public health health departments and 88 nursing home facilities in Montana. The state has 2353 licensed physicians, 599 active licensed dentists, and 81 psychiatrists.

Healthcare for American Indian residents of Montana is provided by a network of services including: Indian Health Service, hospitals/clinics, county health departments; and private health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte.

Because of its large geographic size and small population, Montana has 4.3 hospital beds per 1,000 people, ranking near the high end (47th out of 51) in beds-per-1,000-population compared to the 50 states and District of Columbia. However, Montana ranks low (19th out of 51) with 113 hospital admissions per 1,000 people. Montana ranks on the low end (40th out of 51) in the number of nursing homes in the state (again, because of its small population) and 44th out of 51 in the number of nursing home residents.
Although Montana has 76 home health agencies statewide, home health services are not available in 8 of Montana's 56 counties.

HEALTH INSURANCE: According to 2004 Center for Forensic Economic Studies (CFES) data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in Health Maintenance Organizations (HMO) in 2003, down from 2002.

In November 2008, Montana voters approved the new Healthy Montana Kids program, which expanded coverage under Medicaid and CHIP by raising eligibility levels to 133 percent and 250 percent of the federal poverty line, respectively. The expansion, which went into effect in October 2009, will cover as many as 29,000 of the 34,000 underinsured children in the state.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) STATUS 2010:
Montana continues to face a health care worker shortage. Since 2004, Montana has witnessed a net increase in the number of shortage designations. The active HPSA designations in Montana are:

Number of HPSA's in Montana

HPSA Type	2004	2007	2010
Primary Care	57	90	99
Dental Health	42	56	60
Mental Health	35	49	55

As of January 2010, Health Professional Shortage Areas, which included HPSA facilities, were located in all or parts of Montana's 56 Counties as follows:

- Primary Care: 55 out of 56 counties (98%)
- Dental Health: 48 of 56 counties (85%)
- Mental Health: 56 of 56 counties are designated all or in part as a shortage area.

CONCLUSION: As Montana's population continues to age, demand for all occupations -- including those that are now adequately staffed will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of its older-than-average population.

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The 2010 Needs Assessment resulted in the establishment of six Priority Areas and seven new State Performance Measures to better address the current needs of the MCH population. Montana's aging population, geographic challenges, and access to care issues all pose unique challenges to health care delivery for the MCH population. In some counties, local health departments are the sole source of health care for the surrounding population. Montana's Title V funds, which directly support the local health departments in 54 of 56 counties, are critical to meeting the public health needs of the MCH population across the state.

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/2012/According to 2010 Census data, Montana saw an increase in total population to 989,415; a slight decline from 6.4 % to 6.3% in the number of American Indian and Alaska Native persons residing in Montana, and slight changes in the racial composition: White persons 89.4%; Black persons, 0.4%; American Indian and Alaska Native persons, 6.3%; Asian persons, 0.6%; Native Hawaiian and Other Pacific Islander, 0.1%; persons reporting two or more races, 2.5%

In SY 2011, the Northern Cheyenne Tribal Health Department elected to not renew their Public Health Home Visiting (PHHV) contract, resulting in PHHV being offered by the Rocky Boy/Chippewa Cree Tribal Health Department and by 14 county health departments.

In SFY 2009, Healthy Montana Kids (CHIP) had 25,298 participants under age 20 enrolled in the program and Healthy Montana Kids Plus (Medicaid), had 63,519 participants under age 20.

State funding remains about 5% of the Public Health and Safety Division's total budget. The 2011 legislature's decision to cut the Montana Tobacco Use Prevention Program (MTUPP) funding in half from 8 million to 4 million will significantly reduce MTUPP's ability to fund outreach to specific populations such as those covered by MCH. A few noticeable reductions will be in cessation benefits available, training for home health nurses, outreach to low socioeconomic status groups, and the policy work for smoke free housing. The FCHB and MTUPP partnership will remain; however, it is unknown at this time, the budget cut's impact on MTUPPs availability for providing smoking cessation training to the PHHV and MIECHV Home Visiting programs.

The attached map illustrates FY 2012 MCH services. //2012//

/2013/
According to the MT Census and Economic Information Center, Montana's population increased to 998,199 in 2011. There was relatively little to no change in the racial demographics when comparing 2010 to 2011. It is too soon to predict the public health impact on communities in Eastern MT that have witnessed a population increase due to employment in the Bakken Oil Fields. The attachment illustrates Title V MCH BG and partners' related services across MT.

The Maternal and Child Health Home Visiting Infrastructure Development (MIECHV ID) grant funding has been used to provide technical assistance to high-risk communities and those with existing non-evidence-based home visiting programs to develop infrastructure around early childhood systems, including home visiting. The goal of the funding is for each community to develop a community-based early childhood coalition. The coalition work, discussions, and plans will be informed by community assessments conducted in each community. These resources will make communities better able to respond to funding opportunities, such as those for home visiting, consider how best to transition to or implement evidence-based home visiting, and be sure home visiting and other early childhood programs are integrated into and recognized as a part of an early childhood system by a broad representation of early childhood stakeholders. To date, all 7 of the tribal reservations and 18 counties have participated in the technical assistance opportunities and have applied for or are in the process of applying for funds to develop

coalitions.

The MIECHV ID work will also assist these local and tribal communities in their potential application for Public Health Home Visiting (PHHV) Program funding. In January 2013, communities will have an opportunity to respond to a Request for Proposal for implementing one of the four approved evidenced based home visiting models to begin July 2013.

As explained in greater detail in the Organizational Structure, the Department of Public Health and Human Services is committed to increasing the participation rates in Healthy MT Kids or Healthy MT Kids Plus (formerly known as CHIP and Medicaid). In calendar year 2011, Healthy MT Kids services to children 20 years or younger averaged 18,926 and for Healthy MT Kids Plus services the average was 68,724. For additional information go to: http://www.dphhs.mt.gov/statisticalinformation/Enrollments-Monthly.pdf

The 2011 legislature's decision to cut the Montana Tobacco Use Prevention Program (MTUPP) funding in half from $8 million to $4 million did result in fewer services, i.e. reductions in cessation benefits and less training for home health nurses.

//2013//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Montana's Title V programs are located in the Department of Public Health and Human Services (DPHHS), the largest agency of Montana's state government, with a biennial budget of about $3 billion. DPHHS has 3,100 employees across the state of Montana, 2,500 contracts and 150 health programs. The programs are housed in one of the 11 divisions of DPHHS. The Title V Program is housed in the Family and Community Health Bureau (FCHB) which is within the Public Health and Safety Division (PHSD), one of the 11 divisions of DPHSS. The FCHB is charged with the responsibility of administrative oversight of the Title V Maternal and Child Health Block Grant (MCH BG). This responsibility includes developing and sustaining collaborative public and private partnerships for the purposes of providing maternal and child health care services to Montana's MCH population across Montana's 145,552 square miles, 56 counties, and 7 Native American reservations.

Statutory Authority for Maternal and Child Health (MCH) Services are found in the Montana Codes Annotated (MCA 50-1-2020). General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); acceptance and expenditure of federal funds available for public health services; and use of local health department personnel to assist in the administration of laws relating to public health. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) and Fetal, Infant, Child, Mortality Review (FICMR) are authorized in Title 50.

Rules implementing the above authority are found in Titles 16 and 46 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including children with special health care needs, family planning, school health, and the rules authorizing case management for high risk pregnant women.

The FCHB has a role in ensuring that services and programs to support healthy growth and development are available and accessible to Montana's MCH population. The Bureau budget includes 13 funding sources, of which approximately 96% is federal funding and the remaining 4% is state general fund. The three largest funding sources are from the United States

Department of Agriculture for WIC Administration and Supplemental Food; the Department of Health and Human Services Maternal and Child Health Block Grant; and the Office of Population Affairs Title X Family Planning. Additional federal grants, earmarked for specific programs benefitting the MCH population, round out the FCHB yearly operating budget.

Montana's economic situation is similar to that of the other states: a decline in state revenue has resulted in budget cuts for programs allocated state general dollars. The decline in state general revenue as well as the loss of federal funding to support programs (such as the coordinated school health program, the birth defects registry from CDC, the oral health program from HRSA, and the fetal alcohol spectrum disorder prevention program funding from SAMHSA) contributed to diminished FCHB staff and a subsequent reorganization. In May, 2010 the Infant Child Maternal Health Section was combined with the Maternal Child Health Coordination Section, decreasing the number of supervisory staff by one. The Primary Care Office, Public Health Home Visiting Program, FICMR and Targeted Case Management support functions were moved along with 2.5 FTE staff positions into the MCHC Section. In addition, PHSD leadership created an office of Epidemiology and Scientific Support, which will be led by the State Epidemiologist who is presently being recruited. One of the two MCH epidemiologists is moving to the new office of Epidemiology and Scientific Support. The remaining MCH epidemiologist will continue to focus on MCH issues.

As of May 2010, the 36 staff members of FCHB are organized into four sections, one unit, and one office:

- Maternal Child Health Coordination Section (MCHC),
- Children with Special Health Services Section (CSHS),
- WIC Nutrition Section (WIC),
- Women's and Men's Health Section (WMH),
- MCH Epidemiology Unit, and the
- Primary Care Office.

The FCHB is responsible for coordinating the ongoing MCH Needs Assessment process. Included with this application, is Montana's 2010 MCH Needs Assessment, which is a culmination of the past five years of numerous meetings with public and private partners; gathering qualitative and quantitative data; analyzing the data; identifying MCH priority needs, (as well as emerging needs); assessing the State's current resources, activities, and services; and developing state performance measures based on the FCHB's capacity to provide direct health care services, population based services, enabling services, and infrastructure-building services.

In addition to ensuring the ongoing work on the MCH Needs Assessment, each FCHB section fulfills a role as related to the requirements for receiving the MCH BG. As illustrated on the Agency Capacity Attachment, each section maintains numerous partnerships with public and private entities, which provide preventive and primary care services to the MCH population.

The MCHC Section's primary partners for MCH services are Montana's county health departments. Montana's MCH Administrative Rules of Montana (ARM 37.57.1001) do not require county health departments to accept the MCH Block Grant funding, they can choose to not participate. In FY 2010, 54 of Montana's 56 county health departments accepted MCH funding with the intent of providing MCH services to their populations; two counties opted to not contract with the state to provide MCH services. As part of their contractual obligations, the contracted county health departments select one national or state performance which will be their primary MCH focus. Approximately 42% of the state's MCH BG allocation is distributed to the local health departments.

The MCHC Section also houses the Public Health Home Visiting (PHHV)/ Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Program. The PHHV program is part of the MIAMI act passed by the Montana legislature in 1989. The Legislature has continued to support the PHHV/MIAMI Program with general funds and tobacco trust settlement moneys. The goals of the

MIAMI legislation compliment the charges in Title V of the Social Security Act, which are to: 1) ensure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services; 2) reduce the incidence of infant mortality and the number of low birth weight babies; and 3) prevent the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care.

The PHHV/MIAMI Program has continued to evolve to meet the needs of the MCH population. In Fiscal Year 2010, 14 county health and two tribal health departments provided PHHV services by using a team consisting of a public health nurse, social worker, and dietitian, to provide support and guidance to families who may not be able to access services. Most recently, the PHHV/MIAMI contractors and FCHB staff completed a PHHV reassessment collaborative process whereby changes were recommended to the program requirements. For Fiscal Year 2011, the PHHV/MIAMI contractors will be required to address four outcome measures, which are directly related to the MCH BG: 1) increase the percent of PHHV clients served by the PHHV program who receive adequate prenatal care as measured by the Kotelchuck Index; 2) increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 3) increase the percentage of PHHV infants who are born at a healthy birth weight (2500 to 4000 grams); and 4) increase the percentage of eligible PHHV infants who are exclusively breastfed through 6 months of age.

The FCHB has been selected to provide the leadership and administrative oversight for the state's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program grant applications. Phase I was submitted on July 9, 2010. and Phase II will be submitted on September 20, 2010. The Bureau has engaged in several stakeholder meetings with the Directors of Montana's agency for Child Abuse Prevention and Treatment, Substance Abuse Services, Head Start State Collaboration Office, and Early Childhood Services as well as with other interested stakeholders that are currently providing home visiting services. These meetings have aided in the state's Phase II application and have laid the foundation for the final phase of implementing the ACA Home Visiting grant in Montana.

The Fetal, Infant and Child Mortality Review Program (FICMR) is also housed in the MCHC Section. FICMR is a statewide effort to reduce preventable fetal, infant and child deaths by making recommendations based on multidisciplinary reviews of the deaths. These in-depth reviews bring together a variety of information from many sources and provide a venue for communities to recognize system shortcomings and create strategies to improve these systems. The prevention of fetal, infant, and child deaths is both the policy of the state of Montana and a community responsibility that was authorized in statute (MCA 50-19-401 through 50-19-406) in 1997. The FICMR process identifies critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes. In 2005-2006, 53 of Montana's 56 counties and all 7 Indian Reservations participated in FICMR reviews through 30 local FICMR teams. To date, 89% of fetal, infant and child deaths in Montana in 2005-2006 have been reviewed by local teams. A biennial report is prepared and distributed to policy makers. Policy makers review preventable deaths and strategize at community and state levels on how to address FICMR related issues.

To the extent resources allow, the MCHC also addresses the MCH population's oral health needs. One of the two MCHC Health Education Specialists oversees the Open Wide Program, a free online training program initially developed by the National Maternal & Child Health Resource Center, which is accessible to providers who work with the MCH population, i.e. Head Start and child care providers; WIC; public health departments; and school nurses. Montana's Oral Health Education guide was recently highlighted in the National Maternal & Child Health Resource Center, March 2010, Oral Health Resource Bulletin.
The MCHC Supervisor collaborates with the Early Childhood Services Bureau (ECSB), housed in the Human and Community Services Division, who administers the Early Childhood Comprehensive Systems Initiative Grant (ECCS). The ECCS Grant has supported the

development and training on a Parent Education and Leadership Curriculum; implementing an early childhood mental health consultation model in child care programs; and ongoing support for 18 Community School Readiness Teams. The MCHC Section also ensures the collaborations and partnerships for addressing those national performance measures which are housed in other Departments. These partnerships include working with the State's Suicide Prevention Coordinator, the Injury Prevention and Immunization Sections, and Healthy MT Kids which operates the MCH toll-free line.

Montana's Children and Youth with Special Health Care Needs (CYSHCN) and their families are served by a number of programs that emanate from the Children's Special Health Services (CSHS) Section, which rejoined the FCHB in January, 2006. Prior to 2006, CSHS was located in the Health Care Resources Bureau of the Health Resources Division. Montana is unique in that blind and disabled individuals, under the age of 16 are automatically eligible for benefits under Title XVI. These individuals are also eligible to receive CSHS services.

Data taken from Montana's 2004 - 2008 MCH Block Grant Annual Reports indicates an average of 4,698 CYSHCN received services from a number of programs overseen by the CSHS. CSHS is responsible for system development and service support for children and youth with special health care needs and their families. This section provides regional clinics, direct pay programs, the newborn hearing and metabolic screening programs, and coordination of the state's genetics program.

CSHS works closely with three Regional Pediatric Specialty Clinics (RPSC) which provide medical care for CYSHCN. The RPSC are in Great Falls, Missoula, and Billings, and outreach clinics are conducted in Bozeman, Helena, and Kalispell as well as on two reservations: Wolf Point and Browning. There are three interdisciplinary clinics: cleft/craniofacial, cystic fibrosis and metabolic. The pediatric specialty clinics vary by region, but include: endocrine, genetics, gastrointestinal, hemophilia, high risk infant, muscular dystrophy, neural tube defect, orthopedic, pulmonary, rehabilitation, and rheumatology.

The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking. CSHS continues to support the development of Children's Health Referral and Information System (CHRIS), a data collection system that is interconnected with the RPSC, MT School for the Deaf and Blind, the MT Medical Genetics program, Healthy MT Kids, Social Security Disability, neonatal intensive-care unit (NICU) referrals, outreach specialty providers and others.

January 2008 witnessed the beginning of the implementation of mandated screening of all Montana newborns for 29 conditions as recommended by national screening standards. CSHS has developed and maintained a partnership with the Department's Laboratory Services Bureau which houses the Newborn Screening Coordinator position. CSHS continues to provide the leadership and administrative oversight of the Newborn Screening Follow-Up Program which is contracted with Shodair Children's Hospital.

Throughout the years, the CSHS staff has focused their efforts to secure Healthy MT Kids (formerly known as CHIP) and Healthy MT Kids Plus (formerly known as Medicaid), and private insurance payments for services provided at their regional clinics, with the revenue being reinvested in the CSHS programs and services. A portion of these funds is used to ensure that patients who are uninsured or under-insured are able to attend the interdisciplinary clinics and that they are not charged. CSHS does not collect co-pays or deductibles from patients attending CSHS interdisciplinary clinics.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Their work with Parents Lets Unite for Kids (PLUK), a longstanding advocate for parents and families and the host organization for Montana's Family Voices chapter, centers on

collaboration to improve access to community-based, family-centered services for CYSHCN. CSHS also works closely with the entity providing Part C Services, the School for the Deaf and Blind, Social Security Disability, NICUs, school nurses, Vocation Rehabilitation, and the chronic disease program within DPHHS. CSHS also works with case managers from hospitals (in and out of state), insurance companies, and counties.

The FCHB is home to the state's Title X Agency, the Women's and Men's Health Section (WMH) that has historically received a small portion of MCH Block Grant funds to support their partnerships with 14 Delegate Agencies (DA) offering family planning services in 28 locations serving all 56 counties. WMH is responsible for family planning services through Title X supported clinics across the state. The section also monitors and supports community based efforts to prevent teen and other unintended pregnancies.

In FY 2011, WMH will receive $10,000 for their distribution to the DAs for their efforts aimed at preventing teen pregnancies. The DAs provide reproductive health services, technical assistance, and educational and outreach materials targeting low income women and men, including adolescents.

The DAs are also a designated Sexually Transmitted Disease (STD) Program working closely with the Division's STD/HIV Prevention Section. Additionally, each DA is required to employ a medical service provider who provides comprehensive breast and cervical screening services to an identified target population, as well as provide referral services to other programs, i.e. WIC.

Also housed in the FCHB is Montana's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Section. WIC administers the WIC program in Montana, which offers services through 27 Regional Program contracts with Public Health Departments, hospitals, private non-profits, and tribal organizations with related health or social service programs providing services for all counties in Montana. In 2007, an average of 21, 000 participants per month were provided nutrition assessment and education to improve their eating behaviors; referrals to other health care and social service programs; access to a supplemental food package which now includes fresh fruits and vegetables; and breastfeeding encouragement.

Beginning in 2009, WIC has been involved with developing, implementing, and offering training on MSPIRIT, a new MIS (management implementation system for WIC). It is anticipated that MSPIRIT will provide enhanced data as to the numbers of women initiating breastfeeding, as well as continuing to breastfeed at six months of age and beyond as MSPIRIT links the breastfeeding dyad and food packages being issued. MSPIRIT will also provide data as to the usage of Montana's new WIC Food Package that was rolled out in November 2009. WIC is also the lead for breastfeeding promotion programs through their oversight of the Breastfeeding Peer Counselor Projects (BPCP). Nine Montana communities were funded and operated throughout the year as a BPCP.

WIC also supports the USDA WIC Farmer's Market Nutrition Program (FMNP), which has been operating in Montana since 2002. FMNP participants receive nutrition education related to fruits and vegetables. The nutrition education includes information on selecting, preparing, best time to buy and nutritional value of fruits and vegetables, and the value of physical activity for a family by shopping at their local farmers' market. In 2007, there were seven local WIC programs participating in FMNP: Custer, Flathead, Lewis and Clark, Missoula, Ravalli, Valley and Yellowstone. The WIC FMNP benefits allow participants to purchase locally grown fresh fruits and vegetables. A total of 5,354 women and children were provided the benefit of $16 in FMNP checks for the market season. Participant and farmer responses to the program have been positive.

The MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant, overseeing the 2010 MCH Block Grant Needs Assessment, and submitting the FCHB's Graduate Student Internship Program application, is integral to the FCHB. As mentioned earlier, the PHSD reorganization, upon the hiring of the state Epidemiologist, will result in the

present Epidemiology Unit housing the lead MCH Epidemiologist and the FCHB Data Coordinator. Both these positions work closely with the four sections advising on and conducting epidemiological analyses and evaluation projects for the programs administered by the sections. The Epidemiology Unit provides key services for additional grant opportunities that are submitted by the FCHB, and will be a key player in the state's ACA Home Visiting application.

The Primary Care Office (PCO) was incorporated into the MCHC Section in 2009, but continues to operate as a unique program within the Bureau. The Primary Care Office's responsibilities focus on facilitating federal designation of health professional shortage areas, and supporting recruitment efforts for primary care, oral health and mental health professionals. The PCO compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state. The PCO and Epidemiology Units provided critical data for the state's April 2010 Grants to States to Support Oral Health Workforce Activities, that if funded will move Montana forward by hiring an external evaluator to perform a thorough assessment of the oral health status and needs of the state and expand the MT Area Health Education Center (AHEC) dental recruitment and retention program.

Maternal and child health services are funded not only by the MCH Block Grant distributed to counties, but by local funding, fees and donations and through programs supported with state general funds. As reported in Montana's MCH BG Annual Reports for 2004 - 2009, direct health care, enabling, population based, and infrastructure services were provided to an average of 97,007 clients per year. As reported in Montana's MCH Block Grant 2008 Annual Report, state funding for genetics, home visiting, and newborn screening follow up resulted in a total state match of $2,173,902. In addition, local partners, primarily local health departments, provided additional match of $3,500,746, and program income (including state and local billing and donations) which totaled $914,508. These amounts, combined with the 2008 federal allocation of $2,462,222 totaled $9,051,378 for MCH Services.

The MCH Block Grant data collected by the FCHB indicates that Montana continues to spend the largest portion of funding on children's services, primarily through contracts with local agencies that in turn provide preventive and primary care services for pregnant women, mothers, infants, and children. The local contractors provide:

- Enabling services, such as health education; family support; assistance with enrollment into Healthy MT Kids or Healthy MT Kids Plus (formerly CHIP and Medicaid); and case management;
- Population-based services such as newborn screening and neonatal follow-up; oral health education; public education on preventable deaths; and immunizations; and
- Infrastructure services such as technical assistance for developing standards of care, evaluation procedures, and policy development; and training opportunities at the annual DPHHS Spring Public Health Conference.

The CSHS programs and services for CYSHCN expend 30% of the MCH Block Grant. These services are primarily direct health care services such as the medical services provided at the Regional Pediatric Specialty Clinics and the purchase of medical equipment not covered by insurance.

The Governor's Office provides an annual Tribal Relations Training for state employees to strengthen government-to-government relationships and to ensure that participants have a better understanding of state-tribal policies and principles to integrate into their day-to-day work with tribal governments and people. All FCHB Section Supervisors, as well as several other FCHB staff, have attended this training in the last three years. Recently, the Governor's Office also developed an online training program, designed by the federal government, entitled "Working Effectively with Tribal Governments." The training curriculum has been developed to provide government employees with skills and knowledge they can use to work more effectively with tribal governments.

The FCHB organizes and promotes a yearly Spring Public Health Conference. The planning committee has made it a priority for the opening ceremony to be provided by one of the seven Native American tribes in Montana. The Conference also strives to include at least one breakout session which focuses on health concerns associated with Native Americans.

The role of the Health Resources Division (HRD) is to provide health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan. The HRD provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program. It also provides children's mental health services and health insurance coverage for children through CHIP.

The FCHB's vision is to promote high quality health care services that are delivered in a respectful manner; promote healthy and safe Montana environments (family homes, child care facilities, schools, and communities), and reduce health care disparities within the state. Its mission is "to promote and improve the health and safety of Montana's women, men, children, and families." The FCHB is able to achieve its vision and mission through its ongoing administration of the Maternal Child Health Block Grant and the much needed services this funding provides to the state's maternal child health population.

/2012/Denise Higgins began as Bureau Chief for the Family and Community Health Bureau (FCHB) in December 2010. In February 2011, the FCHB began a series of monthly strategic planning and communication building meetings with the goal of developing a more cohesive bureau responsive to the needs of the Bureau's customers, which include county and tribal health departments, community based organizations, and other governmental agencies within and outside of the Department of Public Health and Human Services.

In the past year, the Public Health and Safety Division (PHSD) added the Office of Epidemiology and Scientific Support, which includes epidemiologists from each of the five Bureaus within the PHSD. The Family and Community Health Bureau's Maternal and Child Health Epidemiology Unit consists of two positions: the Lead MCH Epidemiologist and the Data Coordinator. As of July 2011, the FCHB consists of 35 staff members, with one position vacancy in the Maternal and Child Health Coordination (MCHC) Section, WIC, and the MCH Epidemiology Unit. See the FCHB Organizational Chart attachment in the Organizational Structure Section.

As noted in 2011, the MCHC section within FCHB was designated as the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting (ACA MIECHV) grant administrator. The subsequent required ACA MIECHV grant applications for continued funding have been submitted to HRSA. The Maternal and Child Health Epidemiology Unit provides support and technical assistance for the ACA MIECHV particularly around the benchmark and construct measures and the continuous quality improvement activities.

Additionally, the MCHC Section submitted an application for one of the ACA MIECHV Development Grants (HRSA 11-179) on July 1, 2011. It is anticipated that the MCHC position vacancy will be advertised with the intent to hire an individual to be responsible for the ACA MIECHV projects. This position would work closely with the Public Health Home Visiting (PHHV) Nurse Consultant who provides oversight to the state's PHHV program, a non evidence based model. In SY 2011, one of the two tribal health departments providing PHHV services declined funds, resulting in PHHV being offered through 14 county and one tribal health departments.

In September 2010, the MCHC filled the position for the State FICMR Coordinator. Also in September, the MCHC received the Notice of Grant Award for the Grants to States to Support Oral Healthcare Workforce Activities. The Primary Care Office will apply for the State Primary Care Offices Retention and Evaluation Activities Under the American Recovery and Reinvestment Act Grant (HRSA 11-201) due August 2011.

The WIC program completed the roll out of M-SPIRIT to all local agencies in January 2010. The

system has helped to improve and track services provided by WIC. State staff continues to work with the SPIRIT Users Group to enhance the system to make sure it meets all of the program needs as changes are made in the WIC Program. Data from the system is now able to be used to make program projections and decisions.

In October of 2010 WIC initiated a yearlong outreach project which included statewide bill boards, radio and television advertisements. MT WIC also received a facelift and was rebranded. They developed a new WIC logo and all participant printed materials were redeveloped and distributed to local agencies for use. MT Farm Direct was developed so that the new fruit and vegetable benefits and FMNP benefits could be used at farm stands and farmers markets all across the state. A promotion of "What Incredible Choices" Tool Kit was provided to all Local WIC Agencies to provide ideas and materials for providing education about fruits and vegetables.

MT WIC is completing the planning phase for the transition to EBT from paper benefits. Total implementation is targeted for 2013.

CSHS requested that the Medicaid program conduct a review of non-covered medically necessary items such as over-the-counter vitamins, food thickeners and hypertonic saline, which by is covered by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In the coming year, discussions will continue as to how Medicaid can pay when there is no rebate agreement in place for such items. CSHS will continue exploring opportunities to provide additional nutritional services to clients in the regional areas. CSHS is preparing to apply for the 2012 State Implementation grant by conducting a comprehensive CYSHCN needs assessment by December 2011.

Data from Federal Fiscal Year 2010 collected in Child Health Referral and Information System (CHRIS) shows 5529 children and youth with special health care needs received services from the CSHS Section.

The Women's and Men's Health Section filled their Health Education Specialist position in September 2010. As of July 1, 2011, there are now 26 locations with family planning services serving women from all 56 counties. //2012//

/2013/
The FCHB remains as the administrative entity with oversight of Montana's MCH Block Grant two MIECHV grants, and several other grants supporting Montana's women, infants, children, and their families. Beginning in late Fall 2011, discussions began as to a revised FCHB structure, to best utilize the FCHB Lead Epidemiologist's skills and previous experiences managing programs and the Office of Epidemiology and Scientific Support (OESS).

The Office of Epidemiology and Scientific Support (OESS) maintains and distributes public health data from the following systems:
- ***Montana Behavioral Risk Factor Surveillance System,***
- ***Montana Hospital Discharge Data System, and***
- ***Montana Vital Statistics Analysis Unit.***

These data systems contain information on a wide variety of health issues and thus support the MCH BG/Title V Programs. OESS's main purpose is to provide the most accurate and timely data possible to the Public Health and Safety Division (PHSD) Programs, DPHHS, local health agencies, policy makers, and community groups. OESS strives to protect both the reliability of data being used to support public health functions and policies in Montana and the personal health information that is contained in such data.

FCHB supports a MCH Epidemiologist housed within OESS. This epidemiologist along

with the OESS team have supported Title V projects such as birth record matching for newborn screening and hearing, Fetal Infant Child Mortality Review, analysis of Cystic Fibrosis and Cleft Lip/Palate trends, prematurity and low-birth weight analysis, and teen pregnancy rates. OESS and MCHC collaborated on the data components for this application.

Pending formal approval, the FCHB Epidemiology Unit will be renamed the Maternal and Early Childhood Home Visiting (MECHV) Section with the supervisor being responsible for the MIECHV grants and in January 2013 the Public Health Home Visiting Program (PHHV). Currently, the FCHB MCH Lead Epidemiologist is the Acting MECHV Section Supervisor and has initiated the process of hiring additional staff members. The MCHC Section Supervisor is working closely with the Acting HV Section Supervisor on ensuring that the MIECHV grant requirements are met during the transition period.

The MCHC section recently hired the State FICMR Coordinator, who will provide technical assistance, resources, and guidance to MT's 28 local FICMR Teams. Work continues to adapt the National Child Death Review Case Reporting System, a web-based reporting system housed by the Michigan Public Health Institute. If this new partnership is approved, the anticipated implementation date is January 1, 2013.

The PCO applied and received an ARRA Retention and Evaluation Grant. The PCO partnered with AHEC and the North Carolina Foundation for Advanced Health Programs to determine retention strategies and to implement these strategies with the goal to retain MT's 79 ARRA funded NCHC scholars and loan repayers.

WMHS has experienced several changes in the past year. The Health Education Specialist Position, which became vacant in August 2011, was combined with an existing part-time Program Specialist Position who will work with community programs on teen pregnancy prevention and reproductive health. In May 2012, the WMHS Supervisor retired and the Office Support Specialist resigned. Applications for these two positions are being screened and it is anticipated that the positions will be filled by September 2012.

As of July, 1, 2012 there are 25 Title X family planning agencies providing comprehensive reproductive healthcare to men and women from all 56 counties. The WMHS is in the second of a five year grant, implementing the Personal Responsibility Education Program (PREP) grant that utilizes the Draw The Line/Respect the Line and Reducing the Risk, evidenced based curriculums aimed at preventing teen pregnancy and sexually transmitted infections. The PREP funding was awarded to seven contractors, including two Tribal Health Departments. The PREP Coordinator who was hired the end of June, 2012 terminated her employment to pursue a Peace Corp volunteer position.

In October of 2011 CSHS successfully facilitated the Medicaid coverage of medically necessary vitamins, covered under the EPSDT Policy. These vitamins were previously a non-covered item as there was no rebate agreement in place. Feedback from a regional pediatric specialty clinic and the MT Ancillary Cystic Fibrosis Center and support by MT Medicaid contributed to the change in coverage.

The FCHB organizational structure is changing. In January 2012, the Data Coordinator position formerly in the MCH Epidemiology Unit was transferred to t CSHS. This position works with the newborn screening data sources and software, trains providers and assists in further development of CHRIS. FFY 2011 CHRIS data indicated that 5991 children and youth with special health care needs received services from the CSHS Section.

CSHS received the State Implementation Grant for Systems of Services for CYSHCN beginning July 1, 2012 through June 30, 2015. This grant will further support partnership building, assessment, and provision of education about how to better partner to

coordinate systems of care for CYSHCN.

The WIC Program continued its dedication to the MIS M-SPIRIT by serving on the Executive Steering Committee, the Change Control Work Group, the SPIRIT Users group and the Acquisitions Working Group. These groups ensure SPIRIT users across the country use a product that adheres to WIC guidelines and continues to grow with changing user needs. The WIC Program also tests new releases in-house to check that all new versions are acceptable for use by WIC staff. Montana WIC is now in the implementation stage for the transition to EBT and is collaborating with the SNAP/TANF programs on an EBT contractor Request For Proposal.

WIC also reworked chapters of the Montana WIC State Plan Policy and Procedure Manual to enhance its readability and confirm policies are up to date with current federal regulations. In addition, monitoring procedures were standardized so every local agency strives toward the level of program performance. In May 2012, a dietetic intern reviewed nutrition education material to make sure the information was up to date, and included the required non-discrimination statement.

Since Montana is a large, rural state, the WIC program implemented a distance learning program that allows participants to complete nutrition education away from the clinic. The education is completed online or through videos. A WIC staff member follows up with a phone call and then mails benefits.

The 2011 FCHB Team Building project consisted of a series of seven, 60-90 minute facilitated meetings that focused on such topic areas as essential functions, prioritization methods, conflict resolution skill building, measurable outcomes and quality improvement.

In 2012 PHSD began developing a Performance Management System that enhances the FCHB Team Building project into a performance evaluation system standardized across the entire Division. The Performance Management System is a component of the accreditation process being undertaken by the PHSD.
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An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director of the Department is Anna Whiting Sorrell, who was appointed by Governor Brian Schweitzer in November 2008. She oversees the agency's 3,100 employees, 2,500 contracts and 150 programs. DPHHS is the largest agency of state government, with a biennial budget of about $3 billion.

The Department of Public Health and Human Services (DPHHS) is a "mega agency" encompassing health and human services for the state of Montana. The Department is organized into the Director's Office and 11 divisions. The Director's Office includes offices responsible for legal affairs, human resources, public information, planning and analysis.

The rest of the Department is organized into 11 divisions:

- Addictive & Mental Disorders -- Develops and implements a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.
- Business & Financial Services - Provides professional services for the management of

the Montana Department of Public Health and Human Services.

- Child & Family Services -- Provides services to protect children who have been or are at substantial risk of abuse, neglect or abandonment.
- Child Support Enforcement - Pursues and finances medical support of children by establishing, enforcing, and increasing public awareness of parental obligations.
- Developmental Services - Contracts with private, non-profit corporations to provide services for individuals, and their families, who have developmental disabilities.
- Health Resources - Provides health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan.
- Human & Community Services - Provides cash assistance, employment training, supplemental nutrition assistance (formerly food stamps), Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services for needy families.
- Quality Assurance - Monitors and ensures the integrity and cost-effectiveness of programs administered by the department.
- Senior & Long Term Care - Provides information, education, and high quality, cost effective long-term care services for the elderly and disabled.
- Technology Services - Provides operational and technical support to department programs.
- Public Health & Safety -- see below

Jane Smilie is the administrator of the Public Health and Safety Division. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The state's public health system is a complex, multi-faceted enterprise, including partners such as the City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The Division is organized into five bureaus:

- Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
- Communicable Disease & Prevention Bureau -- Jim Murphy, Bureau Chief
- Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
- Laboratory Services Bureau - Anne Weber , Bureau Chief
- Family and Community Health Bureau -- Jo Ann Dotson, Bureau Chief

Maternal and child health services, as described in the Title V of the Social Security Act, are the responsibility of the Family and Community Health Bureau (FCHB). The Family and Community Health Bureau has a staff of 36 and a total budget of approximately $22 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

- Maternal Child Health Coordination -- Ann Buss, Supervisor
- Children's Special Health Services -- Denise Brunett, Supervisor
- WIC/Nutrition -- Joan Bowsher, Supervisor
- Women's and Men's Health -- Colleen Lindsay, Supervisor

The Bureau also has an MCH Epidemiology Unit, led by Dianna Frick, and the Primary Care Office, led by John Schroeck.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.mt.gov/orgcharts/bureauorgchart.pdf. Organizational charts for the Public Health and Safety Division and the Family and Community Health Bureau are attached as a single document.

/2012/As noted in the updates for Section B: Agency Capacity and Section D: Other MCH

Capacity, the FCHB experienced changes in staffing. The MCH Epidemiology Unit consists of the Lead MCH Epidemiologist and FCHB Data Coordinator, a position that is currently vacant. In December 2010 Denise Higgins began as the Bureau Chief for the FCHB. An updated FCHB Organizational Chart is included as an attachment.

The FCHB total federal FY 2012 budget is approximately $25.5 Million, a $3 million increase. Additional federal funding includes the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting, an increase for WIC's SPIRIT project and a reallocation of funds to the WIC Breastfeeding Peer Counseling project, and the Grants to States to Support Oral Health Workforce Activities.

The FCHB manages 134 contracts for FY 2012, the majority being contracts with local health departments and clinical services.

The 2011 Legislative session approved the Public Health and Safety Division 2013biennial budget request at approximately $3.1 million or 2.4% less when compared to the 2011 biennium. For more information go to: http://leg.mt.gov/css/fiscal/reports/2011-session.asp#ba2013

Information about the Department of Public Health and Human Services can be accessed at: http://www.dphhs.mt.gov/
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DPHHS is focused on ensuring that all families and their children receive the best beginning possible. Therefore, at the state level, there are changes in the initial stages of implementation. In the next 18 months, the Human and Community Services Division will be responsible for family enrollment in either Healthy Montana Kids or Healthy Montana Kids Plus (formerly known as CHIP and Medicaid). These changes are expected to ensure that eligible families are enrolled and receive health care benefits in a timely fashion.

The Public Health and Safety Division witnessed one change in the past year. The new Laboratory Services Bureau Chief's first day is scheduled for August 1, 2012.

The FCHB organizational structure is undergoing changes, which when finalized, will strengthen the Bureau's capacity to more thoroughly address the needs of the maternal and child health population. The influx of the Maternal, Infant, and Early Childhood Home Visiting (MICHEV) funding, led to the creation of a Maternal and Early Childhood Home Visiting (MECHV) Section within the FCHB and a restructuring of the Office of Epidemiology and Scientific Support (OESS). The FCHB MCH Epidemiology Unit will cease to exist once MECHV Section is formalized.

One MCH Epidemiologist from the FCHB MCH Epidemiology Unit was transferred to the OESS and the Data Coordinator was transferred to the Children with Special Health Care Needs Section. These were strategic moves to strengthen the CSHS and OESS capacity to provide ongoing support to Title V projects.

The FCHB Bureau Chief directly supervises the Bureau's Financial Specialist, who now oversees the Bureau's $31 million in funding. The bulk of this funding is allocated through the 180 contracts the Bureau has with public and private organizations supporting the Title V pyramid of services.

For a more detailed explanation of the FCHB organizational structure changes, go to the Agency Capacity. Attached is a copy of the DPHHS organizational chart. Additional information about DPHHS is available at: http://www.dphhs.mt.gov/ and information about the FCHB is at: http://www.dphhs.mt.gov/publichealth/fch/

//2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The MCH BG supports 13.5 FTE at the state level in FFY 2010. Staff supported by the MCH BG are located in the MCHC and CSHS Sections, and in the MCH Epidemiology Unit. The Bureau Chief's salary is cost allocated to all programs and sections, based on the number of staff in the program. Other funding sources supporting staff in the FCHB include other federal funds (WIC, Title X, Newborn Hearing Screening and SSDI) and some general fund and state special revenues.

Key Title V staff in Montana include:

Jo Ann Walsh Dotson, RN, PhD -- Bureau Chief. Dr. Dotson has been the Bureau Chief of the FCHB since December of 1997. Dr. Dotson was an inpatient and outpatient pediatric nurse, and a faculty member in the College of Nursing at Montana State University prior to working for the state. Dr. Dotson's 2009 dissertation evaluated the home visiting program in Montana. Dr. Dotson is retiring from state government in the summer of 2010 -- the position will be recruited with a target start date of fall of 2010. On July 1, 2010 Joan Bowsher, WIC Director, was appointed as Acting Bureau Chief for the FCHB.

Ann Buss, MPA -- MCHC Supervisor. Ms. Buss has been the MCHC supervisor since 2006. She oversees seven staff responsible for general MCH service contract support, public health home visiting, oral health promotion, primary care recruitment and retention and bureau financial and administrative support. Ms. Buss completed her MPA in 2008 and the MCH Certificate program through RMPCH in 2009. She is a member of the Directors' Strategic Planning Committee, and represents the division on the Interagency Coordinating Council for Women. Ms. Buss is also a member of the Legislative and Finance Committee of AMCHP.

Denise Brunett, BA -- CSHS Supervisor. Ms. Brunett has been the CSHS supervisor for two years. She oversees five staff and a contracted staff member responsible for the newborn screening and genetic programs, the regional clinics and CYSHCN referral services. Ms. Brunett represents the division on the HIPAA workgroup

Dianna Frick, MPH -- Lead MCH Epidemiologist Ms. Frick has led the Epidemiology Unit for two years. Ms. Frick has routine meetings with the medical officer who also serves as the state epidemiologist; a new position for a state epidemiologist was created and is presently being recruited to oversee a new Division level office of Epidemiology. One of the two MCH Epidemiologists, Dorota Carpenedo, is being moved to the new office once the lead position is filled. Ongoing coordination of the work of the MCH epidemiology unit with the new office will be needed over the coming years.

Montana CSHS has a CSH Committee that according to its charter, provides crucial input to the program regarding family concerns and needs. On this committee are three parents of children with special health care needs. At this time their involvement has been their attendance at committee meetings. The CSHS manager will continue to encourage as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2)

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated; cost allocation has increased annually for the last several years. In addition, administrative rule and MCH Service contracts allow county health departments to use

up to 10% of the funds allocated to them for administrative purposes.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. Approximately 41% of the MCH BG received by Montana is distributed to counties through MCH contracts. In FY 2010, 54 of the 56 counties were funded and for FY 2011, an additional county indicated a desire to provide MCH services. Those amounts are based on an allocation formula that considers target population and poverty levels. The funding impacts the amount of time and subsequent work which may be "purchased" with the dollars -- some of the smallest counties receive only $1,500 per year. The funding does require that a designated individual be available to monitor MCH needs; the MCH BG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Health Resources Division maintains a Family Health Line. Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line on which Montanans can access information about health care programs for children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to HMK (the Children's Health Insurance Plan), but training has been provided to staff who answer the line to ensure that they are aware of programs to which families may be referred, including, but not limited to CSHS. See the attachment for the FCHB/MCH script.

2012/Denise Higgins, BS-- Bureau Chief. Ms. Higgins has been the Bureau Chief of the FCHB since December of 2010. She holds BS is in Medical Technology from Illinois State University and is certified by the American Society of Clinical Pathologists. Ms. Higgins was the Newborn Screening & Serology Laboratory Manager for the Montana Public Health Laboratory at DPHHS. She was originally hired by the Montana Department of Public Health & Human Services to develop Montana's birth defects registry and conduct Newborn Screening follow-up. She has also coordinated laboratory bioterrorism activities and served as the Departments Planning Chief for the DPHHS Incident Command Team.

Through vacancy savings and the combining of two sections into one section, Montana maintained allocating approximately 41% of the 2010 and 2011 MHC BG amount to the local health departments based on the allocation formula as previously mentioned. The 2012 Pre-Contract Survey results indicate that Liberty County has opted to decline their 2012 MCH BG allocation, bringing the total to three counties declining MCH BG funds. The remaining 53 counties will receive approximately 41% of the anticipated 2012 funding amount, with the smallest counties continuing to receive the $1500 minimum amount.

The MCHC Supervisor, Bureau Chief, and FCHB Financial specialist analyzed the FCHB FY 2012 salary projections and determined that for FY 2012, 10.1 FCHB/FTEs would be supported with MCH BG funding. The FCHB received additional funding through the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) and from the Grants to States to Support Oral Health Workforce Activities grant opportunities.

The 18 member CSHS Advisory Committee, which includes three parents, has a charter membership and delineates the committee members' roles for their participation. Their two 2012 meetings will include local community CYSHCN service providers presenting information about their function in providing services to the CYSCHCN families.

CSHS parents also participated in several additional opportunities in the past year. The Helena area parent representative attended CSHS staff meetings, regularly met with CSHS staff and provided feedback on projects and pamphlets. An additional parent was sponsored to attend the National Early Hearing Detection and Intervention (EHDI) conference in February of 2011. This parent representative continues to provide program feedback, working with CSHS staff and the newborn hearing program physician champion. Another parent, who is not a CSHS Committee

member, is involved with CSHS' cystic fibrosis services and attended the June 2011 CSHS Committee meeting and shared feedback about CSHS cystic fibrosis clinic services.

The CSHS manager will continue to encourage, as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2).//2012//

/2013/

Montana continues to efficiently administer their decreasing MCH BG allocation. The 2013 cost allocation estimate that determined the MCH BG administrative costs is less than 1% higher than the 2012 administrative cost. The 2013 MCH BG will support 10.4 FTE, up slightly from the 10.1 FTE in 2012.

The OESS was created to maintain and distribute public health data from the following systems:

- ***Montana Behavioral Risk Factor Surveillance System,***
- ***Montana Hospital Discharge Data System, and***
- ***Montana Vital Statistics Analysis Unit.***

The OESS Supervisor oversees the placement of student interns interested in maternal and child health. Two Carroll college students interned in the MCHC Section, one who worked on updating the school contact list for providing voluntary oral health screenings and the second who assisted with researching the Public Input plan. A third intern, beginning in September 2012, will work with the OESS MCH Epidemiologist on writing a report summarizing the outcomes of the MT Access to Baby Child Dentistry pilot project completed in December 2009.

The State Systems Development Initiative makes a significant contribution to Montana's ability to report on and interpret data for the MCH BG by facilitating employment of an MCH Epidemiologist who works closely with the OESS, and has access to Vital Records, Medicaid claims data, WIC data, and population data. The epidemiologist position is responsible for the annual assessment of data sources used for the block grant and exploration of new sources.
One MCH Epidemiologist from the FCHB MCH Epidemiology Unit was transferred to OESS. The MCH Epidemiologist along with three other epidemiologists, including the State Epidemiologist, have supported Title V projects such as birth record matching for newborn screening and hearing, matching birth and death files for Fetal Infant Child Mortality Review, analysis of Cystic Fibrosis and Cleft Lip/Palate trends, prematurity and low-birth weight analyses, and teen pregnancy rates. OESS was instrumental in supplying the required data for the application and annual report.

The Data Coordinator position, formerly in the FCHB Epi Unit, was transferred to CSHS in January of 2012. This position was filled in January 2012 by a DPHHS Public Health Laboratory employee with newborn screening knowledge. The inclusion provides much needed data support to the CSHS section, especially in the area of coordinating and assessing newborn screening data.

CSHS was recently awarded a HRSA State Implementation Grant for Systems of Services for CYSHCN. This grant opportunity will include the hiring of a program coordinator who will oversee assessment, education/training and how to better partner to coordinate care for CYSHCN. The goal is for enhanced partnership building with several partners on the State Agency Coordination attachment.

//2013//

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a manageable process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow and many clients are served in common. Local input is regularly sought at the state level and is usually in the form of advisory councils, committees and/or functional work committees.

The Bureau structure facilitates excellent coordination between WIC, Family Planning and MCH Programs. The Bureau organizes and sponsors the Spring Public Health Conference, which provides an excellent opportunity for cross-training between local program staff. Bureau staff also work closely with staff in other bureaus, divisions and sections to address national and state performance measures. Examples of partnerships include coordination of programming to address childhood immunization rates with the immunization program, collaboration with the Health Resources Division on the Family Health Line, and referral of Medicaid and Children's Health Insurance Program (CHIP) families to CYSHCN as needed. Bureau staff participates on advisory groups such as the Montana Council for Developmental Disabilities and includes Family Voices representatives on the Children Special Health Services committee.

The Partnership Diagrams, included as an attachment for the Agency Capacity section, illustrate the Bureau's numerous collaborations with state and private human services agencies across Montana. These partnerships enhance as well as support the Bureau's programs addressing the health care needs of the MCH population, which are reflective of the priority health care needs and performance measures established for 2010.

/2012/The FCHB continued their relationships with their partners as originally stated in 2011. Additional partnerships, illustrated in the Section B: Agency Capacity attachments have been added in the previous year.

Several grant opportunities, such as the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program (ACA MIECHV), Grants to States to Support Oral Health Workforce Activities, and the Montana Best Beginnings State Advisory Council have contributed to the expansion of state, private and community based partners. The ACA MIECHV has resulted in the formation of the ACA MIECHV Agency Work Group, which meets twice a month. This work group is composed of directors of the state's agencies for Title II of the Child Abuse Prevention and Treatment Act (CAPTA); Substance Abuse Services; Child Care and Development Fund (CCDF) Administrator; Head Start State Collaboration Office; State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act; and the Injury Prevention Program. The Grants to States to Support Oral Health Workforce Activities has generated a relationship with the Montana State University/Area Health Education Center (AHEC) to expand educational programs to promote oral health professions by AHEC staff visiting Montana's secondary schools.

Bureau staff members participate on established DPHHS committees and workgroups, such as the WIC Future Study Group and the Injury Prevention Coalition. Staff members have also been invited to participate on new committees, i.e. Western-States Child Death Review Coalition, the DPHHS Director's Office Best Beginnings Strategic Communications Work Group, and the Montana Healthcare Workforce Advisory Committee. Participation on these committees supports the Bureau's educational outreach efforts about the impact that the Title V/MCH Block Grant has on Montana's women, infants, children and families.

The Spring Public Health Conference has been renamed the Family and Community Health Conference. The Children's Health Insurance Program is now the Healthy Montana Kids

program//2012//

/2013/

The partnerships between the FCHB and public and private organizations are critical for addressing the health care of all Montana women, infants, children, and their families. These partnerships, as illustrated in the attachment, are key to addressing the Title V/MCH BG pyramid of services.

Montana received a competitive MIECHV grant for the purposes of assisting the high risk communities with developing their infrastructure with the ultimate goal of MT expanding the number of communities implementing one of the approved evidence based home visiting models. This grant also reinforced DPHHS' commitment to creating a comprehensive and coordinated early childhood system that can lead strong collaboration among all entities serving families with young children. With support of the Governor's Office, the Best Beginnings State Advisory Council was created to expand the focus of an existing early childhood advisory council. The FCHB is partnering with the Early Childhood Services Bureau to minimize duplication of services and to share resources supporting state and local community coalition's creation of their early childhood system. Through a Memorandum of Agreement, each bureau participates on each other's grant planning teams, are members of the Best Beginnings State Advisory Council, and jointly support local community coalitions through blended and braided funding and technical assistance.

The CSHS Supervisor received notification of award for a State Implementation Grant for Systems of Services for CYSHCN. This grant will allow for increased partnerships with the Rural Institute (RI) on Disabilities, Montana's University Center for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD); Parents Lets Unite for Kids (PLUK), the MT Family Voices agency; St Vincent Healthcare; Healthy MT Kids (HMK, formerly known as CHIP); and Healthy MT Kids Plus (HMK+, formerly known as Medicaid).

FCHB staff members participation on DPHHS and other state agency/partners' committees and workgroups continues to serve as a viable tool for sharing educational resources. In addition to the committees listed in the 2012 update, the FICMR Coordinator is participating on the Period of Purple Crying workgroup. This workgroup is assessing the effectiveness and providing recommendations for the mandated Shaken Baby Syndrome educational requirements. CSHS staff participates on the Family Support Services/Part C Advisory Council and the DPHHS Asthma Advisory Group.

/2013//

An attachment is included in this section. IIIE - State Agency Coordination

F. Health Systems Capacity Indicators

Montana continues to assess the indicators and data sources for the Health Systems Capacity Indicators (HSCIs) on an annual basis. The Health Systems Capacity Indicators most relevant to the state are used throughout the year to summarize aspects of maternal and child health.

As explained in greater detail in the State Priorities section, MT recognized seven priority health care need areas for MCH focus in 2010 to 2015. These areas are:

- Child safety/unintentional injury

• Access to care
• Preconception health
• Smoking during pregnancy
• Oral Health
• Montana's rate for the required Varicella immunization
• Montana's rate for the required Diphtheria, Tetanus, and Pertussis immunization series

MT further identified goals to address these health care needs. These goals are: 1) Maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children; 2) Reduce unintentional injuries and deaths among Montanans from motor vehicle accidents, falls, poisoning, and other preventable injury-related deaths; 3) Increase the number of tobacco-free Montanans; and 4) Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis, Varicella and other vaccine preventable conditions.

As a prerequisite for receiving their county's MCH BG allocation, the county health department is required to complete the Pre-Contract Survey (PCS). The 2013 PCS was modified somewhat from the 2012 version, so as to include the county's identification of their community's maternal and child health care need that they would be addressing with their 2013 NPM or SPM selection. As explained in the Needs Assessment Summary section, MCHC staff developed Operational Plans for each county. The Operational Plan is a tool to assist the county's progress in achieving their 2013 MCH BG goal related to their selected NPM or SPM. An Operational Plan is included as an attachment to this section.

To the extent possible, the local health departments address the health system capacity indicators through their NPM or SPM activities. A the state level, the addition of the ACA MIECHV funding has enhanced MT's ability to focus on the maternal and child health needs. The required MIECHV ACA Benchmarks and Constructs included the benchmark: Improved Maternal and Newborn Health and the specific constructs of: prenatal care, well-child visits, and maternal and child health insurance status. MT's proposed performance measures for this benchmark and constructs have the potential to impact HSCI 2, 3, 4, and 7A to the mothers and infants living in one of the four counties (Lake, Lincoln, Flathead, and Mineral) implementing Parents As Teachers or living in the two counties (Yellowstone and Missoula) implementing Nurse Family Partnership. At the time of this submission, MT's Benchmarks and Constructs were being finalized at the state level, prior to final review and approval by HRSA/ACF. A summary of the required ACA MIECHV Benchmarks and Constructs is available at: http://www.dphhs.mt.gov/publichealth/homevisiting/documents/BenchmarksandConstructs.pdf

An attachment is included in this section. IIIF - Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Family and Community Health Bureau (FCHB) has served as Montana's Title V agency for over 20 years. In that capacity, the FCHB has continually monitored, assessed, provided, and advocated, to the extent possible, for the health and well being of the state's women of child bearing age, pregnant women, infants, children and children and youth with special health care needs. The Title V Maternal Child Health Block Grant provides a much needed funding source for addressing the MCH population's unique and oftentimes challenging health needs. In spite of the challenges, an average of 97,007 women, infants, children and children with special health care needs received services supported by the MCH Block Grant.

Montana's 2010 MCH Needs Assessment is a compilation of information, reflecting the work of FCHB programs, and public and private partner organizations. The 2010 MCH Needs Assessment also included input from consumers, which included teens, parents of children with special health care needs, and parents of children and infants ages 0 to 12 years; Montana's Lead Local Public Health Officials; health care professionals; members of the Public Health System Improvement (PHSI) Task Force; and representatives from county health departments that are contracted to provide MCH services in their communities.

There was a consensus from the PHSI Task Force and others working on the SPM selection that Montana must focus on improving Montana's childhood immunization rate; Montana presently has the worst IZ rate for the 19-35 age group in the country. Because of the magnitude of concern, two SPMs were selected to complement the existing NPM 7. SPM #6 focuses on children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis and SPM #7 specifically addresses compliance with the state's requirement of a Varicella immunization for children 19 to 35 months of age. The other five state performance measures address access to care; oral health for children; preconception health; child safety and unintentional injury; and smoking during pregnancy.

Through the years, the FCHB has increased its partnerships and collaborations with other state agencies and private entities for the purposes of providing program activities aimed at any one of the four service levels found in the MCH Pyramid: direct health care, enabling, population-based, and infrastructure building. The new SPMs offer numerous opportunities for developing new partnerships, as well as strengthening the current partnerships, with the goal of maximizing and leveraging when possible, state and federal dollars for the purposes of improving the health of all Montanans, especially the MCH target population.

/2012/

As illustrated in the Agency Capacity attachment, additional partners have been added to the FCHB list of private and public entities addressing any of the services outlined on the Title V pyramid. The Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program grant opportunity has strengthened several established partnerships as well as expanded to new partnerships.

The state's immunization rate continues to be of concern which resulted in the 2012 MCH Block Grant contract being modified. This verbiage, "If NPM 7 or SPM 6 or SPM 7 are selected, the contractor will complete the requirements as outlined on their Immunization Task Order" was included in each contract with the goal of stressing to the health departments the partnership between the FCHB and Communicable Disease Control and Prevention Bureau, which houses the Immunization Program. As stated in the State Priorities section, Montana's immunization rate remains a priority on the Public Health and Safety Division Strategic Plan.
//2012//

/2013/
Montana's public health agencies and immunization providers are working hard to increase childhood immunization rates. As reported in the April 2012, Montana Public Health, Prevention Opportunities Under the Big Sky (see the attachment), this effort is showing results with the state rate and ranking improving among children 19 to 35 months. Recent estimates from the National Immunization Survey (NIS) demonstrate notable improvement. In March 2011, 71.3% of MT children aged 19-35 months were considered up-to-date for 4:3:1:0:3:1:4 series. The national average at that time was 73.1%. The FCHB and the Immunization (IZ) Section are committed to supporting all vaccine providers in an effort to further improve vaccine coverage.

Maintaining and developing partnerships continues as a FCHB priority. In the past year, the new grant opportunities, i.e. MIECHV, ARRA Recruitment and Retention led to an expansion of the number of public and private partnerships. These partnerships support the local and tribal health departments' abilities to provide MCH Block grant services, ranging from Shaken Baby Syndrome education to referrals for dental assistance to well-baby checks. The FCHB partnerships are included as an attachment in the State Agency Coordination section.

//2013//

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

The Family and Community Health Bureau (FCHB) solicited input on the needs of the MCH population, resources and gaps, and capacity through surveys of local partners and programs providing MCH-related services, focus groups, and key informant interviews. In the fall of 2009, 34 topics were initially identified as possible priority areas for the MCH population. These topic areas included exposure to secondhand smoke in childhood, adolescent tobacco, alcohol and drug use, women's mental health and safe home environment. A more detailed list of the thirty four suggested priority areas is included in the 2010 MCH Needs Assessment document.

Subsequent meetings of the FCHB Needs Assessment Planning Team produced a more reasonable list of priority areas. The initial methodology for selecting the priority areas included:

- Relevant to one of the three MCH populations
- Stakeholder/public input indicates an interest or need
- Data available on the topic
- Data supports need
- Capacity to address topic
- Political will/interests
- Not already measured by a National Performance Measure
- Within the responsibility of the MCH or CYSHCN Director
- System in place to address the need
- Topic or issue can be sufficiently focused
- Possible interventions or approaches to address priority area can be identified

After the FCHB Needs Assessment Planning Team narrowed down the list using the criteria, discussions took place with the Public Health System Improvement (PHSI) Task Force. The PHSI Task Force includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service.

The stated purpose of the PHSI Task Force is to:

- Assess Montana's progress in implementing the goals and objectives of the Strategic Plan for Public Health System Improvement and other system improvement efforts.
- Ensure the implementation of the Strategic Plan with updated "action plans."
- Provide policy development recommendations to state and local agencies regarding public health system improvement issues.
- Advocate for statewide public health system improvement efforts.

Source: (PHSITF Charter retrieved 6/7/2010 at http://www.dphhs.mt.gov/PHSD/phsi/pdf/2009-PHSI-TaskForceCharter.pdf)

The PHSI Task Force was responsible for the final identification of the MCH priority areas and state performance measures based on the availability of data on a measure to indicate a baseline or progress toward a goal, the political and financial support/resources to address the priority area, and most importantly, the capacity for addressing the priority area at a state or local level. Furthermore, the PHSI Task Force recommended that the MCH priority areas and new state performance measures have an identified measure that was relevant at either the state or local level.

The following are Montana's priority areas for its MCH population for 2010 - 2015:

- Child safety/unintentional injury
- Access to care
- Preconception health
- Smoking during pregnancy
- Oral Health
- Montana's rate for the required Varicella immunization
- Montana's rate for the required Diphtheria, Tetanus, and Pertussis immunization series

The FCHB is one of five bureaus in the Public Health and Safety Division (PHSD), which has created its own 2007-2012 Strategic Plan to addresses its mission: To improve the health of Montanans to the highest possible level. The PHSD Strategic Plan (attached document) includes several Health Improvement Priorities that target the MCH population and can be tied to a national performance measure (NPM) or state performance measure (SPM), as illustrated:

PHSD Strategic Plan Health Improvement Priority Area and Related NPM and SPMs

Maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children.
NPM #1, #2, #3, #4, #5, #6, #8, #9, #11, #12, #13, #14, #17, #18
SPM #1, SPM #2, SPM #3

Reduce unintentional injuries and deaths among Montanans from motor vehicle accidents, falls, poisoning, and other preventable injury-related deaths.
NPM #10, NPM #16
SPM #4

Increase the number of tobacco-free Montanans.
NPM #15
SPM #5

Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis, Varicella and other vaccine
preventable conditions.
NPM #7
SPM #6, SPM #7

The selection of state needs and priority areas is an ongoing process requiring assessment of

health
status and system functioning indicators as well as the availability of financial and human resources. The fiscal impact of MCH Block Grant funding remaining at the same level for the past several years has been felt in Montana. As mentioned elsewhere in this application, approximately 42% of the state's MCH Block Grant allocation is distributed to 54 of the state's 56 local health departments. Lack of an increase in the MCH Block Grant does not provide for the ongoing increase in the cost of providing services at the local level. Thus, Montana's total number served continues to decrease.

Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure. As the FCHB moves forward with the new priority areas and state performance measures, the FCHB 2010-2015 MCH Block Grant Strategic Plan is the tool that will be used to monitor, assess, and evaluate that the State Title V Agency and the FCHB continue to have the capacity and resource capability for addressing the national and state performance measures.

/2012/

As stated elsewhere in this document, despite the MCH BG funding being decreased, vacancy savings and travel restrictions, have contributed to maintaining approximately 41% to 42% of the funding being allocated to the local health departments for addressing the one National or State Performance Measure for their community. Any monetary changes to a local health department's 2012 funding is the result of their county's 2009 population for women of child-bearing age, children ages 0 to 18, and the number of living in poverty.

The Public Health System Improvement (PHSI) Task Force will continue to provide input to the state priorities, which remain unchanged, and to the State Performance Measures.

As stated elsewhere, the state's immunization rate continues to be of concern and as such is a Health Improvement Priority on the Public Health and Safety Division's (PHSD) Strategic Plan which is attached. Immunization also appears to be a priority area for the local health departments. For SY 2012, 35 of the 53 county health departments opting to receive 2012 funding selected an immunization performance measure: 30 selected NPM 7; 4 selected SPM 6, and 1 selected SPM 7. Additionally, the Bureau Chief is invited to participate on the PHSD telephone conference calls with the Lead Local Health Officials, which when appropriate may include discussion about the PHSD's priority areas.

//2012//

/2013/
Fifty four of Montana's 56 local county health departments accepted their FY 2013 MCH BG allocation, with one county unsure at this time due to staffing issues. Vacancy savings, unexpected staff medical leave, and a reduction in out of state travel, allowed for the local health departments' MCH BG allocation to remain stable at 41%.

As explained in the Needs Assessment and State Priorities Sections, the local health departments select their NPM or SPM based on their community's health care need. Furthermore, they created their Operational Plan focused on their community's need. As illustrated in the attachment, immunization rates remain a high priority, with 37 local health departments selecting NPM 7, SPM 6, or SPM 7.

The FCHB Bureau Chief participates on quarterly conference calls with the Lead Local Health Officials (LLHO). These calls are an opportunity for PHSD Bureau Chiefs to inform the LLHO about program and funding updates. It is also a time for questions and discussion, which includes their perceptions about emerging state health priorities.

These calls are more frequent during legislative session years to keep the LLHO informed of any issues related to county health departments and local boards of health.

As explained in the Public Input section, Montana's Health Improvement Plan outlines key strategies to improve the health of Montanans to the highest possible level. The purpose of the plan is to elevate awareness about specific, strategic public health issues that have the potential to make the most impact on improving health and strengthening the public health system and are amenable to change. The Public Health Improvement Task Force members are very involved with Montana's Health Improvement Plan and in that capacity; state priority areas will be addressed as necessary.

//2013//

An attachment is included in this section. IVB - State Priorities

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	9	17	15	12	3
Denominator	9	17	15	12	3
Data Source		MT newborn screening and follow-up program	MT newborn screening and follow-up program	MT newborn screening and follow-up program	Mt Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011

In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

Notes - 2010
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

Notes - 2009
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

a. Last Year's Accomplishments
The Montana Newborn Metabolic Screening (MT NBS) program is a partnership between Children's Special Health Services (CSHS), the Montana Public Health Laboratory (MT-PHL), and the infant's medical home provider. The MT-PHL received all Montana bloodspot specimens and screened for phenylketonuria, galactosemia, congenital hypothyroidism, hemoglobinopathies, and cystic fibrosis. Specimens were then shipped to the Wisconsin State Laboratory of Hygiene (WSLH) for completion of the American College of Medical Genetics recommended panel. Approximately 4% of babies needed a program-mandated repeat screen due to unsatisfactory specimens or out of range test results on the initial newborn screen.

A high percentage of Montana's newborns (99.2 %) received at least one bloodspot screen in 2011. Of the 11892 infants (with a Montana birth certificate) who received at least one Montana newborn screen in 2011, 33 were screen positive. Of these, 3 were diagnosed with a condition on the screening panel and are being treated (one each with congenital adrenal hyperplasia, classic galactosemia, and a disorder of fatty acid metabolism). An additional 19 infants were presumed carriers of abnormal hemoglobin traits (SCDE) and referred for follow-up services.

In December 2010, MT PHL implemented a more comprehensive referral protocol for reporting out of range results. Results are considered "possible abnormal" (repeat screen required) or "probable abnormal" (presumptive positive). The NBS coordinator tracks most infants with abnormal results to a normal repeat screen.
In January 2011, program partners and cystic fibrosis (CF) specialists reviewed program data and Montana's IRT/ IRT screening algorithm. There were no missed CF cases reported after implementation of mandated CF screening in January 2008. However, age-dependent ranges and timing of the second screen were updated to encourage completion of screening sooner (by two weeks of age), and CF mutation screening added for low birth weight infants. This algorithm was implemented March 2011. Program staff prepared the September 2011 issue of Prevention Opportunities Under the Big Sky "Newborn Screening and Timely Diagnosis of Cystic Fibrosis in Montana".
A new laboratory supervisor for newborn screening began at MT PHL in March 2011. The NBS coordinator worked with her to introduce her to the field so she could provide consistent backup for result reporting and short-term follow-up. Additions to the newborn screening website included information about CF screening, unknown hemoglobin variants, and privacy policies. The CSHS manager and laboratory supervisor met monthly to review and assess NBS program activities.
In August 2011, modifications to the NBS follow-up contract were put in place to provide for direct referrals to appropriate contracted specialists or specialist groups. Board-certified endocrine, hemoglobin, and CF specialists now interact directly with primary providers after presumptive positive results for those conditions. Referrals to the metabolic specialist with the contracted genetics program continued as previously. With the assistance of MCH (Maternal Child Health) Epidemiology, a monthly summary report to contractors was generated from follow-up records beginning in August 2011. De-identified data in this report tracks repeat screening for infants with possible abnormal results and records referral of infants with presumptive positive results.
In September 2011, the NBS coordinator and lab supervisor prepared a survey to be mailed to Montana neonatologists, and an online survey for other intensive care nursery staff. This

stakeholder input, in addition to national expert recommendations form the Clinical and Laboratory Standards Institute will be used in 2012 to develop updated MT recommendations for screening preterm low birth weight, and sick newborns.

An attachment is included in this section. IVC_NPM01_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MT continued with it's surveillance and identification of infants with NBS screened conditions.			X	
2. Update NBS report format			X	X
3. Update referral practices for specific specialists consistent with modified follow-up contract		X	X	X
4. Monitor standardization of SCID screening by regional centers			X	X
5. Review and update Montana's IRT/IRT CF screening algorithm			X	X
6. Newborn Screening Progragm continued to work with Newborn Hearing Screening program and Vital Records to match birth data.				X
7. 33 newborns were referred to specialist, 3 recieved diagnosis of a condition found on the NBS panel.	X			
8. The NBS website was updated.			X	
9.				
10.				

b. Current Activities

The Department is in the process of examining access to and coverage for Severe Combined Immunodeficiency (SCID) diagnosis and treatment as well as funding support for increased follow-up activities prior to possible addition of SCID screening by Administrative Rule. Due to the small number of infants with out of range results, evaluation of the updated Immunoreactive Trypsinogen (IRT)/ IRT screening algorithm for CF has been postponed.

A survey of Montana's neonatal intensive care providers in late 2011 revealed the need for a standardized screening specimen collection protocol and the more written educational materials for NICU staff. In response, a one-page, two-sided, laminated resource was prepared by the NBS coordinator and lab supervisor with NICU screening recommendations, a table of screened conditions, and the effects of common treatments. A flow chart with a recommended screening protocol was also prepared for distribution in May 2012. The newborn screening requisition form was updated in 2012 to include time of birth and collection, NICU admission, and treatments which impact screening results.

The NBS program has begun evaluating the program's need for upgraded data collection and case management software and identifying available options. Expansion of the NBS program website continues as part of a department-wide upgrade.

The CSHS manager and laboratory supervisor continue to meet monthly to review and assess NBS program activities.

c. Plan for the Coming Year

Wisconsin's NBS program is implementing changes in reportable abnormal results which should decrease the false positives for Montana as well. However, it has become apparent that tracking the relatively large number of infants with out of range and invalid results requires investment in appropriate software for short term follow-up. The MT PHL has limited funding to engage in

electronic laboratory ordering and reporting, and will work with larger birthing hospitals on electronic exchange of newborn screening information.
Feedback will be collected from neonatal intensive care providers on the new screening recommendations and educational materials. Briefly, sick and pre-term infants hospitalized for more than 7 days will now receive 2 to 3 screens. Montana opted for simplified screening recommendations based on length of hospitalization rather than birth weight..
The Secretary's Advisory Committee has recommended addition of two conditions (SCID and CCHD) since Montana expanded the mandated panel in 2008. Montana's Administrative Rules for newborn screening were amended in 2008 to add more conditions, but were not otherwise updated. In the coming year, the department will examine necessary rule changes with stakeholder input. Recommendations for screening infants in the NICU will be formalized in rule.
The CSHS manager and laboratory supervisor will continue to meet monthly to review and assess NBS program activities.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12065**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11892	98.6	1	0	0	
Congenital Hypothyroidism (Classical)	11892	98.6	1	0	0	
Galactosemia (Classical)	11892	98.6	1	1	1	100.0
Sickle Cell Disease	11892	98.6	0	0	0	
Biotinidase Deficiency	11892	98.6	0	0	0	
Cystic Fibrosis	11892	98.6	3	0	0	
Homocystinuria	11892	98.6	1	0	0	
Maple Syrup Urine Disease	11892	98.6	3	0	0	
Other	11892	98.6	1	0	0	
beta-ketothiolase deficiency	11892	98.6	0	0	0	
Tyrosinemia Type I	11892	98.6	1	0	0	
Very Long-Chain Acyl-CoA	11892	98.6	5	1	1	100.0

Dehydrogenase Deficiency						
Argininosuccinic Acidemia	11892	98.6	0	0	0	
Citrullinemia	11892	98.6	0	0	0	
Isovaleric Acidemia	11892	98.6	0	0	0	
Propionic Acidemia	11892	98.6	0	0	0	
Carnitine Uptake Defect	11892	98.6	0	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	11892	98.6	1	0	0	
Methylmalonic acidemia (Cbl A,B)	11892	98.6	2	0	0	
Multiple Carboxylase Deficiency	11892	98.6	0	0	0	
Trifunctional Protein Deficiency	11892	98.6	0	0	0	
Glutaric Acidemia Type I	11892	98.6	1	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	11892	98.6	10	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	11892	98.6	0	0	0	
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	11892	98.6	0	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	11892	98.6	0	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	11892	98.6	0	0	0	
S-Beta Thalassemia	11892	98.6	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	55.6	56.5	56.5	56.5	56.5
Annual Indicator	56.5	56.5	56.5	56.5	72.9
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	72.9	72.9	72.9	72.9	72.9

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the2009/10 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of families that had children with special health care needs ages zero to 18 years in MT who partner in decision making at all levels and were satisfied with the services they received was 72.9%. This is greater than the national percentage of 70.3% and the regional average of 69.4%.
CSHS continued to invite parent representatives to the bi-annual CSHS Advisory Council meetings to provide input on Council recommendations. A parent representative took part in regularly scheduled CSHS staff meetings and offered a parent's perspective on program activities and educational materials. CSHS provided funding for the parent of a child with hearing loss to attend the 2012 national Early Hearing Detection and Intervention (EHDI) Conference as part of the state EHDI Team. The team also included the Universal Newborn Hearing Screening and Intervention (UNHSI) Coordinator, a consulting audiologist from the Montana School for the Deaf

and the Blind, a pediatrician designated as the Hearing Champion from the Montana chapter of the American Association of Pediatrics, and a hospital employee from one of the birthing facilities which provides newborn hearing screening services in Montana. CSHS requested the parent representative to share feedback about the conference and UNHSI program activities to program staff and stakeholders to help ensure that the UNHSI program is meeting the needs of Montana families. CSHS restructured the UNHSI Stakeholders' group to include two parent representatives. This group provided input on program activities and helped plan future activities. CSHS continued to request CSHS contractors to conduct client satisfaction surveys and monitor survey results. Results received were analyzed by CSHS in an effort to identify areas in need of improvement to better meet the needs of CYSHCN families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued active parent participation in CSHS Advisory Subcommittee and other section activities.				X
2. Ongoing recruitment of parents of CYSHCN to participate in Advisory Council.				X
3. Ongoing collection and analysis of the client satisfaction survey from the Regional Pediatric Specialty clinics.				X
4. Parent participation and input on the CSHS activity plan.				X
5. CSHS Medical Director to continued to provide technical assistance and guidance.				X
6. CSHS assessed the need for the families of CYSHCN to purchase additional health care coverage		X		
7. Added additional staffing requirements in the 3 regional pediatric specialty clinic sites				X
8. CSHS provided funding for parent to attend annual EHDI conference.			X	X
9. CSHS restructured UNHSI Stakeholders Group to include two parent representatives			X	X
10.				

b. Current Activities

CSHS continues to invite parent representatives to the bi-annual CSHS Advisory Council meetings to provide input. CSHS solicited interest from parent representatives regarding the AMCHP Family Scholar opportunity.

CSHS provided partial funding for a parent representative whose child has been diagnosed with hearing loss to attend the 2012 national EHDI Conference as part of the state Team. The parent representative shared feedback about the conference and UNHSI program activities. The UNHSI Stakeholders' group was restructured and currently includes two parent representatives to provide input on program activities and future activities.

In December of 2011 a CSHS nurse consultant called all 129 cystic fibrosis patients/families served by CSHS CF interdisciplinary team clinics to assess how the patients rate the services and support they received and to ascertain factors that contribute to client service satisfaction or dissatisfaction. Patients and family members were also given the opportunity to voice their opinions on how CSHS and the CF teams could better meet the needs of CF patients in the state. This effort is being used to direct a CF team quality improvement project. The survey results were well received when presented by CF team members at the Mountain West Cystic Fibrosis Consortium Conference in April of 2012.

An attachment is included in this section. IVC_NPM02_Current Activities

c. Plan for the Coming Year

CSHS will continue to invite parent representatives to the bi-annual CSHS Advisory Council meetings to provide input on Council recommendations. CSHS will continue inviting a parent representative to participate in CSHS staff meetings, grant reviews and to offer a parent's perspective on perspective on program activities and materials developed for distribution by the program.

CSHS plans to provide funding to partially support a parent representative 's attendance at the 2013 Early Hearing Detection and Intervention (EHDI) Conference as part of the state EHDI Team. Two parents will continue to serve on the UNHSI Program Stakeholders group to provide their input on program activities. The parent serving as a core team member for the NICHQ IHSIS project will work with the other core team members to ensure that any changes in program procedures continue to address the needs of families with children who have hearing loss.

CSHS will continue to request CSHS contractors conduct client satisfaction surveys and monitor survey results. Results will be analyzed by CSHS in an effort to identify areas of contracted services in need of improvement to better meet the needs of CYSHCN families.

CSHS, a recent State Implementation grantee, will increase opportunities for CYSHCN and their families to partner in decision making through expanded partnership with the MT Family to Family agency, PLUK, to develop a statewide parents as mentors program and a youth advisory council which will provide opportunities for CYSHCN to have a voice in improving systems of care by participating. CSHS will work with the Rural Institute, MT's University Center for Excellence in Developmental Disabilities Education, Research and Service (UCEDD) to further develop the youth advisory board and expand the membership to include at least one youth in foster care.

Additionally, a CSHS will ensure parent involvement in the development, review and implementation of the MT component of the Utah Medical Home Portal.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	52.6	50	50	50	50
Annual Indicator	45.9	45.9	45.9	45.9	39.1
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	40	40	40	40	40

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and

the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
CSHS completed year 3 of the Child Health Referral & Information System (CHRIS) web application development. Much of the work completed during this development phase was case management functionality to assist with coordination of care for children and youth with special health care needs (CYSHCN). Functionality was developed to allow a child's primary care provider to view clinic schedules, access specialty provider information, and make electronic client referrals for clinic evaluations.
CSHS has developed a Cystic Fibrosis (CF) Care Plan which can be accessed by all regional nurse coordinators. The care plan is reviewed with the children and families prior to leaving cystic fibrosis (CF) clinic and a copy of the plan is faxed to the child's primary care provider following clinic.
CSHS contracted with a nurse consultant to assess the different CYSHCN referral sources and develop a referral program that will coordinate CYSHCN care and referrals with county health departments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All regional pediatric specialty clinic participants are tracked and referred to medical home as needed			X	
2. CSHS continues to maintain its website with listings of pediatric specialty clinics and contact information for scheduling.				X
3. CSHS continued to strengthen relationships between the pediatric specialty clinics and primary care providers.				X
4. CSHS completed CHRIS web application development.				X
5. CSHS completed Cystic Fibrosis Care Plan.			X	X
6. CSHS continued contracting with nurse consultant.		X	X	X
7. CSHS continued supporting Medical Home by sending PCP interdisciplinary clinc reports from Cystic Fibrosis, Metabolic, and Cleft clinics.		X	X	X
8.				
9.				

10.				

b. Current Activities

CSHS has been awarded a State Implementation grant which will provide funding to link with the Utah Medical Home Portal project. Montana specific information on available services will be added to the MT portion of the Portal to provide a resource for providers across the state. CSHS and its partners have been meeting to plan the incorporation of MT data.

CSHS will continue the development of the CHRIS web application using fuinding from several sources. Primary development focuses on Regional Pediatric Specialty Clinic scheduling and management functionality to streamline current data entry process. Expanded tracking and management functionality for the UNHSI Program has been completed. Audiology providers now have secure access to CHRIS to enter hearing evaluation results. This functionality enables the UNHSI program to ensure babies are evaluated for hearing in a timely manner and appropriate follow-up and referrals are completed. Also, functionality allowing primary care providers to access clinic schedules has been completed to expand awareness of specialty services available to Montana's CYSHCN.

To facilitate coordination of care for clients attending cystic fibrosis (CF) clinic, CSHS is migrating care plan functionality to the CHRIS web application. This will make care plans more accessible to regional pediatric specialty clinic staff and will allow CSHS to more easily collect data that is important for monitoring client outcomes.

c. Plan for the Coming Year

Implementation of the Utah Medical Home Portal project as part of the recently awarded State Implementation Grant (SI) will be a priority for CSHS during FFY 2013. The Medical Home Portal will provide evidence-based information for CYSHCN to families, physicians and professionals and will also provide national and state specific services and resources. Portal design and information will be reviewed by CSHS parents, PLUK, and a parent volunteer at St Vincent's HealthCare. The Utah Medical Home Portal currently has 10 participating states.

www.medicalhomeportal.org

to enhance the medical home through care coordination activities, SI grant activities will build on current program activities to coordinate care for medically fragile CYSHCN between out of state tertiary care centers and Montana's rural communities. The grant will allow a nurse consultant to conduct ongoing community and state level outreach to assess care coordination needs; participate in care coordination training for local, county and tribal public health nurses; track referral outcomes for care coordination services; and monitor grant activities and their effectiveness.

As part of the SI grant, CSHS will continue working with Medicaid to ensure CYSHCN receive coordinated, comprehensive care linked to a medical home, have improved screening and diagnosis, and receive necessary treatment. This partnership will provide opportunity for discussion about the coverage offered from the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The addition of quarterly EPSDT meetings with the CSHS SI Grant Coordinator and nurse consultants, as well as the continuation of monthly assessment and care coordination meetings will strengthen this partnership. Medicaid staff will provide EPSDT training that will focus on care coordination and assessing policies impacting CYSHCN. Recent HRSA guidelines will serve as tools for State Leadership Workshops on Improving ESPDT through Medicaid and Title V Collaboration.

http://mchb.hrsa.gov/programs/collaboration/state_leadership_workshops_tool_kit.pdf

Ongoing Child Health Referral and Information System (CHRIS) development for FFY 2013 will focus on increased capacity to support coordinated services for CYSHCN. Plans are to enhance CHRIS to allow community user portal development to facilitate referrals between CSHS and public health nurses (PHNs) with care coordination documentation. This will centralize consent tracking for health information shared between CYSHCN service providers and PCP's. Future plans include the ability to generate letters to medical home providers regarding the status of their

client's hearing screening and enhancements to allow PCP access to specific reports and specific client information.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	50.5	55.2	55.2	55.2	55.2
Annual Indicator	55.2	55.2	55.2	55.2	53.3
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	53.3	53.3	53.3	53.3	53.3

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
CSHS continued to monitor the health coverage status of all CYSCHN referred to or receiving services from CSHS using the CHRIS database. CHRIS is a shared application used by multiple CYSCHN service providers, not all of whom collect health coverage information on clients. Better reporting of health coverage data is a quality assurance issue that was addressed for CSHS.

Two Regional Pediatric Specialty Clinic sites became staffed with half-time social workers who worked with families to obtain health coverage and other assistance. This follow-up has been a long term goal for CSHS and has already had a positive impact for families. CSHS continued to support the program expansions of Medicaid (HMK+) and CHIP (HMK). A CSHS staff member attended an extensive Medicaid eligibility training session in July. For FFY 2011 54 CSHS clients were eligible for up to $2,000 in financial assistance using MCHBG funding. Total claims paid $50,948.14 with a cost per child averaging $835.22. All applicants who applied for financial assistance were assessed whether they qualified for HMK or HMK+. CSHS noted additional requests CYSHCN clients needing genetic testing from out-of-state labs and assessed the option of using program funds to cover these services.
Since October 1, 2005 CSHS billed HMK+, HMK, and about 28 private health insurance plans for clients who attended cleft/craniofacial, cystic fibrosis, and metabolic clinics.
For interdisciplinary clinics from October 1, 2010 to September 30, 2011 $231,500.00 was billed and $170,470.67 was paid for cleft/craniofacial; $261,100.00 was billed and $177,956.26 was paid for cystic fibrosis; and $60,200.00 was billed and $43,262.62 was paid for metabolic clinics. Approximately $552,800 was billed; $391,688 was paid; $161,112 was not paid and was written off. CSHS continued to address the outstanding unpaid balance as this revenue allows families to receive medical care in-state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued providing for limited financial assistance for medical services	X			
2. Continued partnership with Medicaid program regarding pediatric specialty services in Montana.		X		X
3. Ongoing shared referrals with Health MT Kids (HMK is CHIP).		X		
4. Communication with providers to accept negotiated rate.		X		
5. Provide information to HMK and other insurance regarding coverage needs of CSHCN.				X
6. Continue providing information to health care providers regarding the HMK expansion		X		
7. CSHS continued billing for three interdisciplinary clinics and using funds to continue support structure of regional pediatric specialty clinics.		X	X	X
8. Suppored MT Family Voices.		X		
9. CSHS provided consultaion to families and providers regarding Early Periodic Screening Diagnosis and Treatment.		X		
10.				

b. Current Activities
CSHS is funding development to improve the collection of health coverage information in the Child Health Referral and Information (CHRIS) data system. CHRIS program data is very useful for understanding the coverage issues that CYSCHN may be experiencing. Hiring a half-time social worker to the 3rd regional pediatric specialty clinic site is under discussion to assist families in accessing health coverage. Knowledgeable, on-site assistance will help those families that are having trouble navigating the health care system. CSHS continues to work with partners, including HMK and HMKP to address services not covered by insurance plans and continues to offer financial assistance for non-covered or non-accessible services to those with public and private health care coverage CSHS offers assistance to achieve health care coverage for those with none. CSHS also offers coverage for out of state genetic testing for CYSHCN. CSHS refers families to patient assistance programs as needed. To date there are 27 clients enrolled in the CSHS direct pay program (Funds allocated to date $53,017.19, services paid to date

$15,218.03, at a cost per client $563.63) and 20 clients are enrolled in the genetics program (Funds allocated to date $21,384.59, services paid to date $11,847.69, at a cost per client $592.38).
CSHS will continue billing HMKP, HMK, and about 30 private health insurance plans for clients who attended cleft/craniofacial, metabolic, and cystic fibrosis clinic.

An attachment is included in this section. IVC_NPM04_Current Activities

c. Plan for the Coming Year
Children's Special Health Services (CSHS) will continue Child Health Referral and Information System (CHRIS) web development with emphasis on accurate collection of health coverage and program assistance data. The data entry process for Children and Youth with Special Health Care Needs (CYSHCN) service providers using the CHRIS application will be streamlined for easier, more accurate data entry. This is important for quality data used for reporting and guidance for Montana's CYSHCN system of care.
CSHS will continue to work with partners, specifically Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMKP) to address services not covered by these entities. HMK does not cover durable medical equipment like nebulizers for children with asthma, oxygen necessities, or CPAP's for children with sleep apnea.
CSHS will continue offering financial assistance for non-covered or non-accessible services for CYSHCN with public and private health care coverage. CSHS will continue advocating for non-covered durable medical equipment coverage through the HMK Program as well as for coverage for out of state genetic testing for the Medicaid population.
CSHS Genetic Laboratory Services Financial Assistance opportunity is housed in the CSHS section. CSHS will continue to disseminate information regarding the genetic testing financial assistance to enable individuals to obtain genetic testing where not otherwise covered by health care coverage. All Montanan's may apply for the genetic testing funding. There are no financial criteria for this assistance; the policy calls for applicants that lack health care coverage for the requested laboratory test.
CSHS was awarded a State Implementation grant for 2012 to 2015. This opportunity will allow for further partnership with Rural Institute (RI) on Disabilities, Montana's University Center for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD). RI, with CSHS support, will assess public and private health care coverage options for CYSHCN in Montana and make updates to the assessment and resource guide. RI will disseminate the updated health care coverage assessment and resource guide as needed to CYSHCN and their families, and to CYSCHN providers. This effort will include research, development, review from CYSHCN and families and dissemination via print and electronic sharing.
CSHS anticipates running a financial assistance outreach campaign that will target public health nurses, county, association web sites such as the Montana Chapter of the Pediatric Association, and mass mailings to providers that service CYSHCN.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	72.8	88.6	88.6	88.6	88.6
Annual Indicator	88.6	88.6	88.6	88.6	54.3
Numerator					
Denominator					

Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	54.3	54.3	54.3	54.3	54.3

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2010 National Survey of CSHCN, 54.3% of MT respondents with CSHCN who can easily access community based services thought their outcome was "successfully achieved", compared to 65.1% nationally.
Because of the distances families travel for care, access to specialty providers continued to be a focal point of Montana's CYSCHN program, CSHS. The cost of travel in a rural state as large as Montana adds to the complexity of accessing care.
CSHS continued to contract with a part-time nurse consultant whose responsibilities include coordinating follow-up community services for newborns and children who are admitted to out of state hospitals.
The North Central Region Pediatric Specialty Clinic administration experienced reorganization. Expansion of pediatric specialty clinic services was on hold until completion of the reorganization process. The Western Region Pediatric Specialty clinic has a strong affiliation with Seattle Children's Hospital which supported the addition of specialty clinic types including Pediatric Gastrointestinal clinics. Also, Seattle Children's Hospital provided pediatric surgical back-up for the Community Medical Center in Missoula. The Eastern Region Pediatric Specialty Clinic continued with stable staffing and continued to expand regional services with the addition of pediatric neurology clinics.
CSHS continued to focus on access to community based care by supporting the three regional

pediatric specialty clinics and coordinating with other programs and agencies which fund or provide services including CHIP (HMK), Medicaid (HMKP), and the MT School for the Deaf and the Blind, and Social Security Disability Determination Bureau. Partnerships with county public health offices, primary care providers, Parents Let's Unite for Kids (PLUK- the MT Family Voices agency), parents, and other partners raised awareness of access to care resources and issues
All 3 regional sites and the Montana Medical Genetics Program (MMGP) conducted outreach clinics to promote better health outcomes.
All 3 regional pediatric specialty clinic sites network with community agencies such as public health, schools, Medicaid Health Improvement Project staff, local providers, Part C agencies, churches, clinics and many other types of supportive community/local agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS continues to promote increased access to specialty care for CYSHCN at the Regional Pediatric Specialty Clinics (RPSC) through contracted services and consultation.				X
2. RSPC clinic development efforts continued to focus on clinical care for clients with CF. Standardized documents for nutrition, social worker, and respiratory therapy were developed and implemented. Care plans were used for reporting and documentatio				X
3. CSHS plans to continue contacting payers that are not reimbursing clinic visits, with the intent to increase payments.				X
4. A Cystic Fibrosis education day to be held annually.			X	
5. CSHS worked with health care coverage agencies to link families to community resources		X		
6. New pediatric specialty providers in MT last year were a pediatric neurologist, a hospitalist/pediatric pulmonologist, and a metabolic geneticist. All are rendering services to CYSHCN.		X		
7. CSHS continued contracting a nurse consultant.			X	X
8. Restructuring of regional pediatric specialty clinics to better serve CYSHCN.				X
9. Continued support to MT Family Voices, County Health Departments, Social Security Department, Part C, and Montana School for the Deaf and Blind.		X	X	X
10.				

b. Current Activities
CSHS continues to contract with and provide consultation to the 3 Regional Pediatric Specialty Clinics (RPSC). The RPSC are crucial partners in the pediatric health care system in Montana. CSHS is seeking sustainable funding for nutrition and social work services at the RPSC. In addition to staff from the three CSHS sponsored clinics (Cleft/craniofacial, Cystic Fibrosis, and Metabolic Clinics), the county health departments are providing ongoing follow-up for RPSC clients.
CSHS works with families to facilitate the transition of adults with cystic fibrosis to adult clinic services. CSHS has continued development of the referral follow-up system for CYSHCN who receive care out of state, have extended stays in Newborn Intensive Care Units, and have special needs by expanding its linkages with public health home visiting, Part C, Medicaid (including Medicaid Health Improvement Program), CHIP, private payers, out-of-state hospitals and primary care providers.
CSHS has been awarded a State Implementation grant to further support care coordination. A grant supported effort in partnership with PLUK, parents, and St. Vincent's Healthcare, to join with

the Utah Medical Home Portal, allowing for the listing of MT specific resources for providers and families of CYSHCN in now under way. The project will provide national and state specific services and resources for CYSHCN which can be easily accessed in an online format by parents and families, physicians and professionals.

c. Plan for the Coming Year

CSHS will continue to support access to pediatric specialty care across the state through the Pediatric Specialty Clinics (RPSC). The RPSC sites have plans to add additional clinic disciplines to the specialty services now provided. CSHS will work to replicate the Eastern Region staffing model in the other RPSC sites for greater staff efficiency and to promote family centered, comprehensive care. CSHS is exploring options with partners to develop an extended care coordination model for the RPSC sites.

CSHS was awarded a State Implementation grant to further support care coordination. A grant supported effort will be to join efforts with the Utah Medical Home Portal, allowing for the listing of MT specific resources for providers and families of CYSHCN. This partnership with PLUK, parents and St Vincent's HealthCare will allow for an online evidence-based information source for parents and families, physicians and professionals and lists national and state specific services and resources for CYSHCN.

Also a result of the SI grant, CSHS and the Rural Institute (RI) on Disabilities, Montana's University Center for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD)will be an assessment of public and private health care coverage options for CYSHCN in Montana and make updates to the assessment and resource guide as needed. The RI will disseminate the updated health care coverage assessment and resource guide as needed to CYSHCN and their families, and to CYSCHN providers. This 3 year effort will include research, development, review from CYSHCN and families and dissemination via print and electronic sharing. It is anticipated CSHS and RI will partner with the Catalyst Center, as they have experience and expertise in this project area.

CSHS and the RI will continue the partnership effort to provide 6 webinar trainings on topics addressing education, work, independence, social networking and health care for CYSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6.5	46.5	46.5	46.5	46.5
Annual Indicator	46.2	46.2	46.2	46.2	48.6
Numerator					
Denominator					
Data Source		CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	48.6	48.6	48.6	48.6	48.6

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
CSHS actively sought out new partners to increase its collaborative efforts to address transition issues faced by Montana youth. Collaborative efforts with Summit Independent Living began to provide improved transition services in the Missoula area. New funding sources were identified and discussed with partners in preparation for upcoming grant opportunities.
Staff from Shodair addressed transition issues for youth ages 14-18 by providing education, referral to services, and information on resources available in Montana.
Information on transition from health care programs such as HMK and HMK Plus to other payment sources was sent to families along with applications for financial assistance.
A CSHS Staff member served on the MT-TIRC Advisory Board. Through the MT-TIRC board, CHSH funded 6 webinars focusing on transition issues such as Social Security and youth transitioning into handling their own medical affairs in adulthood. Communication with health care payers helped youth and their families address complications that occur when youth transition into adult care/services.
CSHS worked with the Department's IT staff to discuss possible website enhancements and explore online transition resources available to youth. A list of transition resources was reviewed with the intent of developing a webpage that will provide information and identify available transition resources.
The Montana Cystic Fibrosis (CF) teams identified transition to adult care as a focus of effort for clinic staff.
CSHS invited Summit Independent Living to attend the CSHS Advisory Council meeting in June of 2011. The Summit Independent Living staff shared with the Council the Youth Opening Doors though Advocacy (YODA) program, the work done in schools and information about the Disability Awareness Panels. The Council appreciated the presentation and welcomed the staff to attend

Council meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions.		X		
2. Explored options to collaborate with several new organizations who serve youth in transition and their families.				X
3. A CSHS staff member is a member of the MT-TIRC Advisory Board and attends the quarterly meetings.				X
4. Continued work with existing partners to identify transition resource opportunities and funding opportunities.				X
5. Sought out new partners to increase transition collaborative opportunities.			X	X
6. CSHS provided funds for six webinars.			X	X
7. CSHS worked on including Transition to the website.		X	X	X
8. CSHS and Cystic Fibrosis teams identified Transition as a focal point for improvement.			X	X
9. CSHS invited guest presenter to Advisory Council.			X	X
10.				

b. Current Activities

CSHS staff sends transition information with CSHS financial assistance applications and provides information to families regarding transitioning from health care programs such as HMK and HMK Plus to other payment sources. Collaborative efforts between CSHS and Parents Lets Unite for Kids (PLUK), the Rural Institute, and Summit Independent Living continue. Other opportunities for collaboration are being explored to identify new transition resources and activities in Montana. A new webpage has been added to the CSHS website to provide transition information and resources. New funding has been obtained through an additional HRSA grant to support limited transition activities. CSHS communicates with other CYSHCN state programs and Association of Maternal & Child Health Programs (AMCHP) about challenges and opportunities s to provide improved transition services and information to Montana youth and their families.

Shodair Hospital, a contractor of CSHS, is working with youth aged 14-18 on transition issues at genetic and metabolic clinics. Regional Cystic Fibrosis clinic coordinators are working on a transition check list for children and families. The checklist is now in draft form and will be implemented during fall 2011 clinics.

Communication with healthcare payers by CSHS staff helps address issues that arise when youth transition into adult services.

A CSHS staff member continues to serve on the MT-TIRC advisory board.

An attachment is included in this section. IVC_NPM06_Current Activities

c. Plan for the Coming Year

A CSHS staff member will continue to serve on the MT-TIRC board to provide input on transition activities and identify resources available in Montana. The transition webpage will be more fully developed to provide up to date information for children and families on transition resources and services. CSHS will continue to provide assistance to families who are working with healthcare providers during the transition to adult services. Partnerships will continue with other agencies who work with children and families in the transition process.

CSHS will also works closely with the Rural Institute (RI) on Disabilities, Montana's University

Center for Excellence in Developmental Disabilities Education, Research, & Service (UCEDD), to provide support to the CYSHCN transition projects and the Consumer Advocacy Council (CAC). RI will continue it's goal to enhance the quality of life for people with disabilities, especially those individuals living in Montana and other rural areas by increasing the independence, productivity, community integration, and inclusion of those with disabilities through education, research, and demonstration services.
CSHS will contract with the RI to expand existing CAC to include youth with special health care needs, American Indian youth, and youth in foster care. The CAC will create opportunities for CYSHCN to share feedback on program materials related to transition topics, education, mentoring, and focus work groups. The meetings will be held four times a year, one occurring face-to-face. The RI will provide CAC member orientation, education and mentoring for new members to promote youth advocacy.
Regional Cystic Fibrosis clinic coordinators plan to implement a standardized cystic fibrosis transition check list for children and families. The checklist will be used as a tool to assure transition issues for children and youth with cystic fibrosis and their families are taking the time to assure successful transition in life and health care.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	80	80	70	65
Annual Indicator	75	65.5	60.1	66.7	66.7
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	66.8	66.8	66.8	66.8

Notes - 2011

The source of data is the National Immunization Survey (NIS), Data are from 2010, data for 2011 (4:3:1:3:3) are not yet available.

Notes - 2010
The source of data is the National Immunization Survey (NIS), Please note the 95% confidence interval is +/-6.7. The data for 2010 are final.

Notes - 2009
The source of data is the National Immunization Survey (NIS), July 2008-June 2009 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0809.htm). The data for 2009 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 7.0.

a. Last Year's Accomplishments
The Montana Department of Public Health and Human Services (DPHHS) Immunization Program continued to encourage and support vaccination activities throughout the state, including:
1. Replacement of the Immunization Information System (IIS) with a modernized IIS which meets all 12 National Vaccine Advisory Council functional standards for an IIS.
2. Enforcement of child care and school entry immunization requirements through contracts with local health departments.
3. Increased collaboration between WIC programs and Immunization Programs, through contracts with local health departments, to review immunization records for WIC program participants.
4. Increased collaboration between local health departments and private providers in each jurisdiction to implement best practices and increase immunization rates.
5. Provided Quarterly Reports to all Vaccines for Children Providers, to be used for quality improvement purposes, enabling them to identify and recall children who were missing or coming due for immunizations.
6. Encouraged testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of positive test results to state or local health departments for case management and follow up.

The Family and Community Health Bureau (FCHB) which houses the Maternal and Child Health (MCH) Coordination Section provided technical assistance and programmatic support to local health departments which selected National Performance Measure (NPM) 07.

In SFY 2012, the following 30 counties selected NPM 07 as their focus and conducted activities to help improve immunization rates in their counties.

Beaverhead
Blaine
Butte-Silver Bow
Carbon
Carter
Cascade
Chouteau
Custer
Daniels
Dawson
Fallon
Fergus
Flathead
Gallatin
Glacier
Judith Basin
Madison
Meagher

Park
Phillips
Powder River
Prairie
Roosevelt
Rosebud
Sanders
Sheridan
Sweet Grass
Teton
Toole
Wibaux

An attachment is included in this section. IVC_NPM07_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Replaced of the Immunization Information System (IIS) with a modernized IIS which meets all 12 National Vaccine Advisory Council functional standards for an IIS.				X
2. Enforced child care and school entry immunization requirements through contracts with local health departments.				X
3. Increased collaboration between WIC programs and Immunization Programs, through contracts with local health departments, to review immunization records for WIC program participants.				X
4. Increased collaboration between local health departments and private providers in each jurisdiction to implement best practices and increase immunization rates.			X	X
5. Provided Quarterly Reports to all Vaccines for Children Providers, to be used for quality improvement purposes,				X
6. Encouraged testing of all pregnant women for Hepatitis B infection and reporting of positive test results to state or local health departments for case management and follow up.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

The FCHB developed an Immunization Activity Guide for local health departments to provide them with best practices to improve immunization rates in their counties.

The Public Health Home Visiting (PHHV) program will assess whether infants in the program receive their two, four and six month immunizations and the PHHV provider will counsel parents on the importance of continuing scheduled immunizations for infants.

The Children with Special Health Care Needs (CSHCN) Section will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS Immunization Section will partner with 53 contractors to improve the immunization rates in Montana. The Immunization Section has monthly phone calls with all local health department partners to provide technical assistance and programmatic support.

c. Plan for the Coming Year
The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization information system.
• Providing outreach and referrals for children identified by immunization information systems who are missing or coming due for immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**

Annual Performance Objective	17	16	16	17	17
Annual Indicator	16.8	18.6	18.9	13.0	13.0
Numerator	343	367	359	247	247
Denominator	20388	19782	19015	19023	19023
Data Source		Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17	16	16	16	16

Notes - 2011
Data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Notes - 2010
Data reported are for 2009. 2010 data are not yet final. They are expected to be available later in 2010.

Notes - 2009
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2009. The denominator is the latest mid-year population estimate (May 2010 release) for females ages 15-17 in Montana in 2009.

a. Last Year's Accomplishments
From 1995 to 2007, the United States teen birth rate, for 15-19 year old females, declined by approximately 23%. During the same time period in Montana, the teen birth rate, for 15-19 year old females, declined by 12%. In 2007, 20 states had teen birth rates lower than Montana's. In Montana we focus on females ages 15-17 specifically, and in 2010 there were 247 births to females aged 15-17.

The Women's and Men's Health Section (WMHS) maintained contracts and provided technical assistance with 14 Delegate Agencies (DAs), offering services in 25 locations representing all 56 Montana counties. DAs ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, education information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of these reproductive health services and supplies. In SFY 2011, the DAs served an estimated 6,697 adolescents and also provided

specific outreach projects designed for adolescents at high risk for teen pregnancy and birth.

The Health Education Specialist (HES) organized a statewide campaign for Teen Pregnancy Prevention Month in May. Outreach packets were created that included a press release, sample letter and updated teen pregnancy rates for Montana. The HES also attended a Teen Pregnancy Prevention Coalition meeting in Great Falls in November 2010 that discussed the current pregnancy rates for Cascade County.

The State Family Planning Information and Education Committee (SFPIEC) met in June 2011 to review and plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "Get Checked MT" HIV Campaign through outreach campaigns and toolkits provided by HES.

In August 2010, The Nurse Practitioner (NP) met with Regional Training Advisory Committee (RTAC) and evaluated the DAs and Region VIII Title X agencies training needs for the 2011 annual family planning training. The March 2011 training focused on clinicians and motivational interviewing with adolescents and lesbian, gay, bisexual, transgender, questioning, and intersexed individuals. The NP also attended Region VIII training on Reproductive Health Education in May 2011.

The Office of Population Affairs (OPA) distributed funds to WMHS which was allocated DAs for expanding male services; dispensing highly effective & emergency contraceptives; and expanding services targeting low income women and men, including adolescents.

WMHS received the Personal Responsibility Education Program (PREP) grant to address teen pregnancy prevention utilizing evidenced based curriculum. The Request for Proposal was issued in April 2011 and focused on two age groups Middle School utilizing the Draw the Line, Respect the Line; and High School utilizing Reducing the Risk curriculum. WMHS selected seven contractors across Montana with two located on reservations that have a high teen pregnancy rate.

WMHS worked with Family and Community Health Bureau Health Education Specialist to develop "Strategies for Prevent Teen Pregnancies in Montana" provides a brief overview of how to plan an approach that fits their community.

WMHS disseminated information through the online newsletter which included funding opportunities, upcoming trainings and events, and information for Title X agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained contracts and provided technical assistance with 14 Delegate Agencies			X	X
2. Organized a statewide campaign for Teen Pregnancy Prevention Month			X	X
3. Evaluated the DAs and Region VIII Title X agencies training needs				X
4. Addressed teen pregnancy prevention utilizing evidenced based curriculum.			X	X
5. WMHS disseminated information through the online newsletter to Title X agencies			X	X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
WMHS provides technical assistance and contracts with 14 DAs, representing all 56 MT counties. The DAs provide reproductive health services, and educational and outreach materials to residents.

WMHS distributes information to local DAs on current teen pregnancy rates and trends on a yearly basis. This year the HES will work with OESS to publish Trends in Teen Pregnancy Report in fall 2012.

SFPIEC meets on a yearly or as needed basis to review and plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and "Get Checked MT" HIV awareness through outreach campaigns and toolkits.

The HES did not meet with RTAC as it has been discontinued due to funding cuts.
OPA funding is distributed to DAs for dispensing highly effective & emergency contracep tives. Additional funding for low income men and women was not included this year.

WMHS continues to address teen pregnancy prevention utilizing evidenced based curriculum through the PREP grant. Orientation training was conducted in October 2011 for all 7 contractors. WMHS disseminates information through the online newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies.

WMHS collaborates with other agencies that serve high risk youth to prevent teen pregnancy. WMHS presented to Foster kids on the importance of delaying children and using contraception in June 2011.

c. Plan for the Coming Year
Women's and Men's Health Section (WMHS) will contract and provide technical assistance with 14 Delegate Agencies (DAs), offering services in 25 locations representing all 56 MT counties. DAs will ensure that women and men of reproductive age, including adolescents, have access to comprehensive reproductive health care, education information, and services that include how to prevent unintended pregnancy. The agencies' sliding fee schedules will be based on family size and income. The sliding fee schedules will also ensure the affordability of these reproductive health services and supplies.

WMHS Health Education Specialist (HES) will continue to coordinate with the Office of Epidemiology and Scientific Support to distribute information to local DAs on current teen pregnancy rates and trends on a yearly basis.

SFPIEC meets on a yearly or as needed basis to review and to plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and "Get Checked MT" HIV awareness through outreach campaigns and toolkits provided by HES.

HES will work with John Snow Institute (JSI) to coordinate the Montana Family Planning Training Conference in the spring 2013. Topics on health education and adolescents will continue to be part of the training to ensure family planning staff are providing up to date and relevant information to teen patients on preventing teen pregnancy. HES will continue to be a part of the Family and Community Health Conference planning committee and support presentations on teen pregnancy prevention.

WMHS will continue to seek funding from the Administration for Children and Families for teen pregnancy prevention through the Personal Responsibility and Education Program grant.

OPA funding will continue to be distributed to DAs for dispensing highly effective & emergency contraceptives targeting low income women and men, including adolescents.

WMHS will continue to disseminate information through the on-line newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies.

WMHS will continue to collaborate with agencies serving youth at risk of pregnancy. WMHS would like to increase linkages with Foster Care to assist youth with transitional living plans. Also, collaborating with the Pregnancy Assistance Fund (PAF) for pregnant and parenting teens, which may include subsequent pregnancy prevention, would be beneficial for both programs. PAF is administered by the Child and Family Health Services Bureau. WMHS will continue to look for more opportunities to collaborate and reduce teen pregnancies in Montana.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	40	46	46	46	46
Annual Indicator	45.9	45.9	45.9	45.9	45.9
Numerator	4693	4805	4773	4915	4908
Denominator	10225	10468	10398	10707	10693
Data Source		05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	46	46	46	46	46

Notes - 2011
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2010-2011 school year from the Montana Office of Public Instruction.

Notes - 2010
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2009-2010 school year from the Montana Office of Public Instruction.

Notes - 2009
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2008-2009 school year from the Montana Office of Public Instruction.

a. Last Year's Accomplishments
During the 2010 -- 2011 school year, 95 schools conducted voluntary Basic Screening Survey (BSS) of children enrolled in public schools across Montana. A total of 1,912 3rd graders were screened. The survey found that 62% of 3rd graders screened did not have sealants and only 37% of 3rd graders screened had received protective sealants on at least one permanent molar tooth.

The summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" was finalized and distributed to oral health stakeholders. It was also made available to the public on the Family and Community Health Bureau (FCHB) Oral Health website http://www.dphhs.mt.gov/publichealth/oralhealth/

The FCHB Oral Health (OH) program produced oral health educational materials which provide age-appropriate materials for teachers of children in grades 1-5. Each section focuses on one grade level and provides a summary of objectives and resources as well as talking points, handouts, coloring pages, games, illustrations, and lessons. Topics include the importance of teeth and oral hygiene, tooth development, tooth decay and prevention, importance of sealants and nutrition. All materials are available on the FCHB Oral Health website http://www.dphhs.mt.gov/publichealth/oralhealth/

The FCHB offers the Open Wide program (online oral health education program) to child care providers, WIC staff and school nurses. The Open Wide curriculum stresses the importance of sealants. Upon completion of the Open Wide program participants are eligible for 2 continuing education credits from Montana's Early Childhood Project. In State Fiscal Year (SFY) 2010 there 210 participants who completed this training and in SFY 2011 there were263 participants who completed this training.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Voluntary Basic Screening Survey			X	
2. Summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" was finalized and distributed				X
3. Oral health educational materials		X	X	
4. Open Wide program		X	X	X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Through a grant from HRSA, the Oral Health Program will partner with Montana State University, Area Health Education Center to increase dental recruitment and retention efforts for the state and to develop and present dental career education modules for high school students.

The Oral Health Program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The Oral Health Program will continue to offer the Open Wide program which provides oral health education to child care providers, WIC staff, and school nurses.

Collaboration with Head Start was increased and a new, uniform dental exam form was drafted for use by all participating Head Start programs in the state. This new form will allow for analysis of oral health data by site and provide valuable information to communities seeking to address oral health issues.

School-specific reports on school-based oral health screenings conducted will be distributed to participating schools and oral health coordinators.

c. Plan for the Coming Year
Through a grant from HRSA, the Oral Health Program will continue to partner with Montana State University, Area Health Education Center to increase dental recruitment and retention efforts for the state and to develop and present dental career education modules for high school students.

The OH program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The OH program will continue to offer the Open Wide program which provides oral health education to child care providers, WIC staff, and school nurses.

Collaboration with Head Start will continue to collaborate on the development of a new, uniform dental exam form which will allow for analysis of oral health data by site and provide valuable information to communities seeking to address oral health issues.

The OH Program will release a report summarizing the accomplishments and challenges of the ABCD program. Individual reports will be available for the participating health centers and a comprehensive report will be released to the general public.

School-specific reports on school-based oral health screenings conducted in the 2011-2012 school year will be distributed to participating schools and oral health coordinators.

The OH Program will continue to seek funding to implement school-linked dental sealant/varnish programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4.3	4	6	6	5.4
Annual Indicator	5.6	6.2	5.6	7.6	7.6
Numerator	10	11	10	14	14
Denominator	177577	178565	179583	184312	184312
Data Source		MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5.4	6.5	6.5	6.5	6.5

Notes - 2011
The data reported are for 2010. Final data for 2011 were not available at the time of grant submittal.

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
Denominator data are from the updated July 1, 2009 census estimates for the population of 0-14 year olds in Montana (May 2010 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Offive of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

a. Last Year's Accomplishments
The Fetal Infant and Child Mortality Review (FICMR) Coordinator continued to support state and community injury prevention efforts by providing educational meetings/trainings and continued to be a resource via phone, email or through in-person contact and shares prevention information with local coordinators. Current journal articles and information related to infant and child death prevention, specific to motor vehicle safety, car seat and seat belt use were sent electronically to local coordinators.

In the Fall of 2011, local FICMR coordinators met with the state coordinator to discuss the program and identify areas of improvement prevention of deaths due to motor vehicle crashes. The local FICMR Teams continued to review child deaths and implement community activities related to prevention of child deaths due to motor vehicle accidents.

In April of 2011, the FICMR Coordinator attended the National Conference for Child Death Review (CDR) at the Center for Disease Control in Atlanta, GA.

The FICMR Coordinator attended quarterly Emergency Medical Services Council (EMS) Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The FICMR Coordinator was a member of the Western Regional State Child Death Review Coalition which addresses deaths due to motor vehicle accidents, specific to rural/frontier states. The FICMR coordinator worked with the epidemiology team for statistics related to this type of death.

The FICMR Coordinator continued with trainings and meetings to educate coordinators on how to accurately complete the State of Montana Fetal, Child and Infant Mortality Review Case Report.

FICMR is currently evaluating the use of the CDR reporting tool, with the intention of participating in the National CDR data collection system to better understand child deaths, including those caused by motor vehicle accidents. The approval from the Maternal and Child Health Coordination (MCHC) supervisor to move forward with this system was the accomplishment of last year's activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational meetings/ trainings/resource		X	X	
2. Current Journal Article information and prevention information distributed		X	X	X
3. MT evaluated use of CDR Reporting Tool				X
4. Prevention Coalition and EMS Advisory Meetings				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FICMR Program provides technical assistance to communities for development of activities and policies to reduce the rate of motor vehicle deaths to children. This is achieved through 1) partnerships with 28 local coordinators, especially those in counties experiencing higher rates, 2) collaborating with other agencies, such as EMS, to prevent motor vehicle deaths, and 3) the development of resources and tools for community education and activities/policies to reduce motor vehicle deaths.

Local FICMR Teams continue to review child deaths and implement community activities related to prevention of deaths attributed to motor vehicle crashes. The FICMR Coordinator assists in the sharing of practices and prevention activities to standardize reporting and collaboration.

The FICMR coordinator is a member of the Safe States Alliance, the Western-States Coalition for

Child Death Review, the EMS Advisory team, and the State Injury Prevention Coalition. FICMR coordinator attends meetings as scheduled to discuss prevention campaigns and strategies at the federal, state and local level.

The FICMR coordinator attended a meeting in December 2011, to discuss the life-course perspective and how FICMR can work with several partners to decrease the rate of child deaths.

Efforts continue for Montana to implement the National CDR reporting system.

c. Plan for the Coming Year

The FICMR Program will continue to support community and state efforts in targeting the rate of deaths to children aged 14 and younger caused by motor vehicle crashes. The plan to target the rate of deaths caused by motor vehicle crashes is to 1) work collaboratively with 28 local coordinators, especially those in counties experiencing higher rates, 2) work collaboratively with other agencies to target motor vehicle crashes, and 3) development of resources and tools for community education and activities/policies to reduce motor vehicle deaths.

Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of deaths attributed to motor vehicle crashes. The FICMR Coordinator will continue to assist in the sharing of practices and prevention activities to standardize reporting and collaboration.

The FICMR coordinator will continue to be an active member of the Safe States Alliance, the Western-States Coalition for Child Death Review, the Emergency Medical Services Council Advisory team, and the State Injury Prevention Coalition. FICMR coordinator will attend meetings to discuss prevention campaigns and strategies at the federal, state and local level.

Montana continues efforts towards implementing the Child Death Review (CDR) Data Reporting system sometime in 2013 to improve national and local data, as well as prevention activities, related to child deaths due to motor vehicle accidents.

The FICMR program will partner with community and state organizations, such as the Office of Public Instruction's Traffic Education Program, which provide support to new parents about car seat installation, child transportation safety, and parental responsibility when in and around cars. FICMR Coordinator will collaborate with providers and organizations, especially those that can intersect with the Maternal, Infant and Early Childhood Home Visiting program's benchmarks addressing injury prevention, to address injury prevention education and activities.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	29	54	54	57	57
Annual Indicator	52.1	52.9	56.8	55.4	61.1
Numerator					
Denominator					
Data Source		National	National	National	National

		Immunization Survey	Immunization Survey	Immunization Survey	Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	57	58	58	58	58

Notes - 2011
The data reported for 2011 are from the CDC/National Immunization Survey 2011, for children born in 2008. The 2008 data is final.

Notes - 2010
The data reported for 2010 are from the National Immunization Survey for children born in 2007. The data are final.

Notes - 2009
The data reported for 2009 are from the National Immunization Survey for children born in 2006. The data are final.

a. Last Year's Accomplishments
Twelve local programs were funded for Breastfeeding Peer Counselor (BPC) projects this year. Three programs, Hill, Lewis and Clark, and Silver Bow were initiated during the year. All hired and trained a BPC. This was the first year we required reporting on two of three measurable indicators. This data will provide more information as trends become apparent. Local programs selected measureable indicators that they would report on for the year. They will have the option to change their choices after this first year, to an indicator which would be more reflective of their BPC project.

The November 30th and December 1st training for BPCs and the BPC Supervisors was well received. Staff took home many usable ideas from the training and have implemented some of them during the year. Future trainings were requested, but will be dependent on the funding Montana receives to operate the BPC projects.

The BPC project monitoring tool continues to be revised. Revision of the main body of questions was begun and will be tested through use in monitoring visits during FFY 2012. Exploration of methods to select a random sample of charts for review will be conducted in FFY 2012 and 2013.

The WIC newsletter was utilized to provide information about upcoming breastfeeding conferences and workshops. In addition, the information about IBCLC study courses for the exam was also provided.

Near the end of the fiscal year, Montana was able to order breast pumps utilizing WIC

Administrative funds. All three types of breast pumps were ordered, multi-user, single-user and manual. Local programs ordered breast pumps from the State Office on a quarterly basis.

The Montana Breastfeeding Coalition continues. New leadership is being established. The State Breastfeeding Coordinator continues to be active and connected to the Coalition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued Breastfeeding Peer Counselor (BPC) trainings				X
2. BPC project monitoring tool revisions.				X
3. The WIC newsletter was utilized to provide information			X	X
4. Provided breast pumps to local programs for distribution		X		
5. Continued involvement in the Montana Breastfeeding Coalition				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Eleven local agency WIC programs received BPC project contracts. One prior local agency WIC program was not offered a BPC project contract because the FFY2010 contract was never authorized. Final funding for the FFY 2012 BPC project is unknown at this time.

The State WIC Director and the WIC Breastfeeding Coordinator (BC) attended training on the new Loving Support Training for BPC. The training will be shared during a face-to-face training or during bi-monthly conference calls.

USDA announced it will not sponsor the WIC BCs to attend the US Breastfeeding Committee Conference in August 2012. Based on funding, the BC is not planning to attend.

Opportunities for breastfeeding continuing education are presented in the WIC newsletter. Local agency WIC programs are encouraged to attend the National WIC Association Conference being held in Denver this year. The program has a track for breastfeeding sessions.

A bi-monthly conference call was established in March. The call will allow another means of communication between the BC and the local BPC projects to discuss questions, issues and program information.

The BC worked with the Reports Subcommittee of the MSPIRIT Users Group on the revision and/or acceptance of various reports. Several requests for changes or enhancements were submitted. As changes and revisions are delivered, the Committee will meet to determine acceptability.

The BC is participating in the Montana Breastfeeding Coalition.

c. Plan for the Coming Year

Montana WIC promotes and supports breastfeeding by encouraging local program staff to establish and maintain a breastfeeding friendly clinic. Many of our local programs have a breastfeeding room within their area for participants and staff to use. The local Breastfeeding

Coordinator is encouraged to obtain Certified Lactation Counselor or International Board Certified Lactation Consultant status. Other local program staff are also encouraged to hold and maintain these certifications.

All local programs may issue breastpumps. Three types of breastpumps are available for issuance, a manual, a single-user electric and a multi-user electric. Local programs will be encouraged to issue multi-user breastpumps for those breastfeeding dyads meeting the criteria for an electric breastpump. Increasing the utilization of multi-user breastpumps will result in a more effective use of our funds and allow us to be able to provide more breastpumps to WIC participants. Breastpumps were not ordered in FFY 2012, but a plentiful supply was ordered in the prior fiscal year.

Information about breastfeeding continuing education events is provided in the weekly WIC newsletter which all WIC staff receive or can access at the WIC website.

Each local program has been provided various resources on breastfeeding to assist them in addressing breastfeeding questions and issues. All are reputable resources varying from textbooks to physician references to La Leche League materials.

Montana WIC will maintain the 11 local Breastfeeding Peer Counselor Programs (BPCP). If interest by other local WIC programs is shown, they may apply. It is expected that USDA funding for the BPCP will remain consistent with the current year and initial funding of 2013 contracts will reflect that.

A 1-2 day conference for the breastfeeding peer counselors (BPC) and their supervisors is being planned for early FFY 2013. Suggested topics were solicited from the BPCs during an earlier bi-monthly conference call. The presenters will be experts in their area. Other WIC staff requesting to attend will be accommodated as space allows. Invitations to other DPHHS programs interested in breastfeeding will be made.

Bi-monthly conference calls for the local BPCP were established during FFY 2012. These will be continued throughout 2013. The BPC and their supervisors are updated on various breastfeeding topics and can share information or solicit information and advice about an issue.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	92	94	94	94	98.5
Annual Indicator	93.1	93.0	97.7	97.8	98.1
Numerator	11403	11669	11448	11408	11346
Denominator	12249	12551	11719	11666	11571
Data Source		MT newborn hearing screening system, Hi-Track	MT newborn hearing screening system, Hi-Track	Newborn Hearing Screening System and birth records	Newborn Hearing
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	98.5	98.5	99	99	99.2

Notes - 2011
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2011. It does not include births to Montana residents that occurred in hospitals out of state or births that occured outside hospitals..

Notes - 2010
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2010. It does not include births to Montana residents that occurred in hospitals out of state. As of 2009, the data reported are only for infants born in hospitals, to more closely correspond with the guidance for reporting on this performance measure. The data entered for 2010 are provisional.

Notes - 2009
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2009. It does not include births to Montana residents that occurred in hospitals out of state. The data were updated for the 2011 submission to reflect only hospital-based births.

a. Last Year's Accomplishments
The UNHSI program continued to collect hearing screening data on all babies born in Montana's birthing facilities each month. Feedback was provided to birthing facilities to ensure all screening information was submitted and follow up was completed on babies who did not pass inpatient screens or babies not receiving an inpatient screen. The program continued to work with out-of-state hospitals to access screening information on babies who were transferred out of state. Primary care physicians were contacted by the program manager to ensure follow-up on babies with refer screening results. Audiologist's submissions of diagnostic testing results were monitored to make sure any baby diagnosed with a hearing loss was electronically referred to MSDB. Quality assurance visits to hospitals continued to ensure proper documentation and reporting to the program and monitor facility screening protocols. Quality assurance reports were provided to the facilities to improve reporting accuracy and compliance with state law. Educational materials continued to be provided to program partners. Funding continued to provide updated screening equipment to hospitals. Grant applications for the UNHSI grant and the EHDI grant were submitted and funded. The annual CDC Newborn Hearing Screening survey was completed and submitted. Newborn Hearing Screening Stakeholders group was restructured to include a hearing champion from the Montana American Academy of Pediatrics and two volunteer parent advisors, a pediatric audiologist, a consulting audiologist from the

Montana School for the Deaf and the Blind, a hospital staff member, and the UNHSI program coordinator. Stakeholders provided input on program activities and program improvement strategies in an effort to reduce lost to follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect hearing screening data and provide feedback monthly			X	X
2. Quality assurance visits and reports to birth facilities to monitor documentation and screening protocols.				X
3. Educational materials provided to program partners.			X	X
4. Provided updated screening equipment to hospitals		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The UNHSI program collects data monthly on all babies receiving newborn hearing screening and provides feedback to birthing facilities. The UNHSI program continues to provide reporting software to birthing facilities and audiologists. Collaboration continues with hospitals, audiologists, midwives, PCPs, OPI, and MSDB. A pilot project started in early 2012 to provide screening equipment to two county health departments in order to offer additional screening resources for babies born outside of hospitals. Screening equipment was provided for 3 hospitals. Diagnostic equipment for one audiologist was funded by the program--increasing the number of pediatric audiologists to 6 in Montana. On-site QA visits were completed at 6 hospitals and several midwives in order to monitor and improve reporting of screening results. A .5 FTE data coordinator was hired to assist in managing hearing screening data and enable the program manager to focus additional time on follow-up activities in order to reduce lost to follow up. Two meetings were held with UNHSI stakeholders to discuss program activities and plans for program improvement. The Stakeholders group includes two parents of children with hearing loss, an audiologist, a hospital staff member, the MT AAP Hearing Champion, the consulting audiologist from MSDB, and the program coordinator. A learning collaborative project has been started with NICHQ to focus on program improvement in the areas of diagnosis and referral

An attachment is included in this section. IVC_NPM12_Current Activities

c. Plan for the Coming Year

Hearing screening data collection from all 29 birth facilities in Montana will continue throughout the year. Screening records will be electronically matched to birth records to identify any infants who did not receive screenings. Quality assurance activities, which include on-site visits and monthly data reviews, will continue to ensure that all screenings are documented accurately. Hospitals will also receive quarterly reports that will help them identify specific areas of reporting that need improvement and show comparisons of their performance with other birth facilities in the state. The Children's Health Information and Referral System (CHRIS) system will be upgraded to complete the birth certificate match process, track hearing screenings, and ensure follow-up on those babies who do not receive timely screenings in the hospital or need follow-up screenings. Collaborations will continue with Part C, MSDB, OPI, Midwives, Audiologists, primary care providers, and hospitals to increase the number of babies who are screened and provide needed follow-up. The UNHSI Program will complete the CDC Early Hearing Detection and Intervention annual hearing screening report. Funding will be provided to two hospitals for the purchase of updated screening equipment. The UNHSI program will continue to provide

reporting software and help desk support to all birth facilities. Stakeholders meetings will be held twice during the year to review current activities and upcoming projects so that they can provide input as needed. Educational materials will be evaluated, updated as needed, and distributed to birthing facilities, audiologists, midwives, and physicians. The UNHSI Website will be updated to provide information targeted to screening staff, parents, and medical professionals.
The NICHQ Learning Collaborative project will be completed. This project will require a large commitment from a core team which includes the UNHSI Coordinator, the data coordinator, the MSDB consulting audiologist, and a parent. An additional extended team will assist in the project. This team will be made up of 2 Early Intervention Providers, 2 audiologists, the AAP Hearing Champion, parent representatives, hospital personnel, and other interested parties.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	16	14	13	11	11
Annual Indicator	14.8	14.2	11.9	10.2	10.2
Numerator	35686	34417	28863	24197	24197
Denominator	241206	242716	241672	237267	237267
Data Source		US Census CPS Table Creator II	US Census CPS Table Creator II	US Census; CPS Table Creator II	US Census; CPS II
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11	12.1	12.1	12.1	12.1

Notes - 2011
from Current Population Survey Annual Social and Economic Supplement, conducted 2011
Refers to status in 2010

Notes - 2010
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2010 for health insurance coverage in 2009. The data for 2010 will be collected in 2011 and become avilable in 2012 for health insurance coverage in 2011. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2009
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2009 for health insurance coverage in 2008. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

a. Last Year's Accomplishments
The percent of children in Montana without health insurance for SFY 2010 was 10.2 percent, which shows an improvement from SFY 2009: 11.9% and SFY 2008: 14.2%.

The Healthy Montana Kids (HMK) program was implemented October 1, 2009 and expanded eligibility to families under 250% of the federal poverty level. The Healthy Montana Kids Plan covers kids by: 1) expanding eligibility for the Children's Health Insurance Program (CHIP) and Medicaid children's coverage; 2) offering premium assistance to eligible parents who add children as dependents to their employer-sponsored health plan; 3) using "enrollment partners" to actively enroll eligible kids; and 4) using federal matching funds to pay most of the cost. The HMK program has two levels: Healthy Montana Kids Plus (same program as Medicaid) and Healthy Montana Kids (same program as CHIP). HMK is a free or low-cost health coverage plan. The plan provides health coverage to eligible Montana children and teenagers up to age 19. A child can qualify for HMK based on family size and income. This program not only increased the number of children in the state with health insurance, but also reduced the number of children who fell through the gaps between Medicaid and CHIP eligibility. Healthy Montana Kids and Healthy Montana Kids Plus were intended to facilitate continuous coverage of children whose families are under 250% of the federal poverty level, whereas previously coverage may have fluctuated if children's eligibility shifted from Medicaid to CHIP or vice versa.

In SFY 2010, Healthy Montana Kids (CHIP) had 24,197 participants under age 20 enrolled in the program and Healthy Montana Kids Plus (Medicaid), had 63,519 participants under age 20.

The HMK program continued its efforts to increase the number of children enrolled in the Healthy Montana Kids program. Children with health coverage have greater access to preventive and acute health care services. HMK continued to work towards its goal of improving the health of Montana families.

CHIP and Medicaid continued their efforts to increase the number of children enrolled in the Healthy Montana Kids (HMK) program.

The Family and Community Health Bureau (FCHB) used the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. During this time period, NPM 13 was not selected as a focus for block grant efforts by any local health departments.

In October 2010, the Primary Care Office (PCO) collaborated with the Primary Care Association (PCA) and HMK to produce informational materials about MT's Community Health Center locations and the National Health Service Corps sites. These materials were distributed in an HMK monthly mailing to families. The contact information included how to access the listed medical care providers. See attachment.

Children's Special Health Services (CSHS) monitored the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage. CSHS refered, linked, and counseled families to utilize available sources of health care coverage such as Medicaid, State Children's Health Insurance Program, Caring for Children Program and Comprehensive Health Association of ND (CHAND).

WIC continued to ensure that families were referred to Healthy Montana Kids or Healthy Montana Kids Plus.

An attachment is included in this section. IVC_NPM13_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Montana Kids provided quality, comprehensive insurance coverage for Montana children		X		
2. HMK program continued its efforts to increase the number of children enrolled in the Healthy Montana Kids program.		X		
3. CSHS refered, linked, and counseled families to utilize available sources of health care coverage		X		
4. Collaborated to produce informational materials about MT's Community Health Center locations and the National Health Service Corps sites			X	X
5. WIC continued to ensure that families were referred to Healthy Montana Kids or Healthy Montana Kids Plus.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program.

The FCHB uses the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB assists any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids in their communities.

An HMK monthly mailing to families includes contact information and how to access enrolled medical care providers.

Children's Special Health Services (CSHS) monitors the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage. CSHS refers, links, and counsels families to available sources of health care coverage such as Medicaid, State Children's Health Insurance Program, Caring for Children Program and Comprehensive Health Association of ND (CHAND) as well as to other assistance programs.

WIC ensures that families are referred to Healthy Montana Kids or Healthy Montana Kids Plus.

c. Plan for the Coming Year
CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program. Both parties will continue to work towards their shared goal of improving the health of Montana children.

The FCHB will use the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB will also assist any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids within their communities.

Families will be required to apply for Healthy Montana Kids or Healthy Montana Kids Plus prior to eligibility determination for CSHS services. This will allow families to have more comprehensive

healthcare coverage. Families who apply for HMK or HMK+ who have a CSHCN will be offered referral to services through the CSHS program.

The Primary Care Office (PCO) will continue to work with the Primary Care Association and Healthy Montana Kids on updating the information about Montana's Community Health Center locations and the National Health Service Corps sites for ongoing distribution in HMK mailings.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	30	29	31	31
Annual Indicator	33.6	33.7	33.3	40.0	40.6
Numerator	3706	3876	3957	5099	5274
Denominator	11029	11492	11878	12744	12978
Data Source		WIC Program Enrollment	WIC Program Enrollment	WIC Program Enrollment	WIC Program Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	31	31	31	31	31

Notes - 2011
The source is the Montana State WIC Program. Data are for FFY 2011.

Notes - 2010
The source is the Montana State WIC Program. Data are for FFY 2010. The increase in the indicator for 2010 is believed to be due to a change in data systems. Some records may be duplicated. As a result, the objective was not increased based on the 2010 data. Montana will reassess the objective next year when a full year of data from the new data system will be available.

Notes - 2009
The source is from the MT State WIC Program. Data are for FFY 2009.

a. Last Year's Accomplishments

Montana WIC established a policy for distance nutrition education for selected participants. The materials were reviewed and selected. Training for staff on the appropriate use of distance nutrition education was conducted in September 2011. Some of the materials addressed obesity prevention such as breastfeeding, fun fitness, and food selection.

Infants and children continue to be weighed and measured for WIC certification, when appropriate. Children at a Body Mass Index (BMI) greater than the 85th percentile must be referred to a Registered Dietitian (RD). All local programs were required to have an RD on staff, under contract or with a Memorandum of Understanding (MOU) to assist high-risk participants. All local programs have made arrangements for an RD, but a few are still formalizing those arrangements.

Twelve local programs were funded for Breastfeeding Peer Counselor (BPC) projects this year. Three programs, Hill, Lewis and Clark, and Silver Bow were initiated during the year. All hired and trained a BPC. This was the first year we required reporting on two of three measurable indicators. This data will provide more information as trends become apparent. Local programs selected measureable indicators that they would report on for the year. They will have the option to change their choices after the first year, to an indicator which would be more reflective of their BPC project.

At the Family and Community Health Conference, local program staff were given redemption information on the Fruit and Vegetable Benefit (FVB) and the WIC Farmers' Market Nutrition Program benefit (FMNP) for June 2009 to January 2010. In the spring of 2011, they were given the redemption information for June 2010 to January 2011. Local programs were encouraged to think of ways to increase the redemption of the FVB and to share their ideas during future WIC Conference Calls. The change in redemption percentage for the FVB was from 62.98% in 2010 to 78.08% in 2011. Ideas to promote the FVB ranged from cooking classes, providing recipes and sampling to using store receipts for purchases using the FVB in a raffle for food preparation items.

The second season of Farm Direct with authorized farmers occurred this past summer. There was an increase in the redemption of WIC FMNP benefits primarily because of an increase in over issuance (approximately 1.5 times as many benefits were issued for the available food dollars). Almost all of the WIC FMNP food dollars were expended. Redemption of FVB at authorized farmers showed only a slight increase.

Funding was again requested to develop local staff training for competencies in Value Enhanced Nutrition Assessment (VENA), but was not approved for this fiscal year. It is planned to make the request again next year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Policy for Distance Nutrition Education				X
2. Anthropometric Measurement of Children	X			
3. Breastfeeding Peer Counselor Program		X		
4. Promoting Redemption of Fruit and Vegetable Benefit and the WIC Farmers' Market Nutrition Program Benefits		X		
5. Development of Local Staff Training Materials			X	X
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The MT WIC Program purchased items for nutrition education for use with participants through distance delivery. Distance delivery will allow participants to use the materials for their next WIC appointment. After completing the education, the participant receives follow-up on the topics with the WIC staff by phone. Benefits are mailed upon completion and an appointment set for the next visit.

MT WIC will be using modules at wichealth.org and identified 3 DVDs (Food for Thought, Reggie & the Veggies: Family Fun and Fitness, and Breastfeeding: You Can Do It!) for use with participants.

RD services for high-risk participants (care plan development, nutrition education, coordination with other health care providers and follow-up) are now available through distance delivery using secure meeting software, iPads and telephone.

The change to one year certifications for children was implemented on October 1, 2011. Children are to be weighed and measured at the certification and the mid-certification visits.

Local WIC programs that selected the performance measure to increase the redemption of fruit and vegetable benefits are in the middle working on achieving their target. Those meeting their target will receive bonus funding.

WIC and the Nutrition and Physical Activity Program have met to discuss possible joint projects. Current funding for WIC, including Operational Adjustment funding, does not include any extra funds for special projects other than Electronic Benefit Transfer.

c. Plan for the Coming Year
WIC and the Nutrition and Physical Activity Program have met to discuss possible joint projects. Current funding for WIC, including Operational Adjustment funding, does not include any extra funds for special projects other than Electronic Benefit Transfer (EBT).

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15	14	14	14	13
Annual Indicator	15.9	15.0	13.4	13.2	13.2
Numerator	1668	1893	1630	1578	1578
Denominator	10509	12595	12155	11990	11990
Data Source		Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	13	13	13	13	13

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator does not include women with unknown smoking status in the third trimester. This indicator is believed to be an under-report of the actual number of women smoking during the last trimester.

a. Last Year's Accomplishments
SFY 2011 Public Health Home Visiting (PHHV) contracts included the requirement, under services to be provided, "Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy." Home visitors followed The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet at intake of clients to assess tobacco use and plan intervention for those who use tobacco.

Using state moneys, the FCHB funded 15 PHHV programs, 14 county and one tribal health departments, which promoted the Montana Tobacco Quit Line through information and referrals for their pregnant women and infant/family units. The PHHV home visitors also referred clients to other community cessation programs.

In SFY 2011, all the PHHV sites were visited at least once during by a PHHV Nurse Consultant. Quality assurance checks were conducted and site-specific reports were compiled and sent back to each site.

PHHV sites entered PHHV client data elements into a common electronic data system. Data on outcomes related to pregnant women using tobacco products, cessation of tobacco use, and referrals to cessation resources were collected by all of the PHHV sites.

The PHHV clients received information from the PHHV home visitor on the effects of tobacco and secondhand smoke during pregnancy and on the infant.

In FY 2011, the Lake County Health Department was awarded ACA Maternal, Infant Early Childhood Home Visiting (MIECHV) Program funds to implement the Parents As Teachers (PAT) model. A contractual requirement was to address the ACA MIECHV benchmark/construct performance measure: Decrease smoking among primary caregivers and pregnant MIECHV participants. It is anticipated that over the life of the MIECHV funding, the data will verify that

Lake County met this performance measure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home visitors followed The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet at intake of clients to assess tobacco use and plan intervention for those who use tobacco.				X
2. The FCHB promoted the Montana Tobacco Quit Line and other community cessation programs.		X	X	X
3. All the PHHV sites were visited by a PHHV Nurse Consultant. Quality assurance checks were conducted and site-specific reports were compiled and sent back to each site.				X
4. Data on outcomes related to pregnant women using tobacco products, cessation of tobacco use, and referrals to cessation resources were collected by all of the PHHV sites.				X
5. The PHHV clients received information on the effects of tobacco and secondhand smoke during pregnancy and on the infant.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The state contract with the fourteen counties and one tribal health department requires the site visitors to assess tobacco use and intervene with adults who smoke in situations where fetuses and children may be compromised. The PHHV contractors assessed and intervened in smoking by adult clients using the U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet located at:http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm.

Referrals were usually made to the Montana Tobacco Usage Prevention Program (MTUPP), another DPHHS entity. Other tobacco cessation sites are the recipients of referrals from home visitors. Sometimes clients, based on individual assessment, were referred to psychological treatment services or private physicians for smoking cessation.

The ACA MIECHV funds continue to provide funds to additional counties for home visiting services. Lake County was joined by Lincoln, Mineral and Flathead County Health Departments for implementing PAT and Yellowstone and Missoula are implementing Nurse Family Partnership (NFP). See the attachment.

ACA MIECHV funds require collection of data on quantifiable, measurable use of tobacco. Improvement is defined as rate decreases over time. Each site is collecting data related smoking in the pregnant women and caregivers. Tobacco usage by pregnant women will be measured pre- and post-natally with an expected outcome of reduction of smoking by the cohort over time.

An attachment is included in this section. IVC_NPM15_Current Activities

c. Plan for the Coming Year

During the coming year, the contract in effect between the DPHHS/FCHB and the local Public Health Home Visiting (PHHV sites) will be continued with the same activities as the SFY 2012 contract being carried out by the contractors. The home visitors in the fifteen contracted sites will be expected to assess tobacco use of each pregnant women and primary infant caregivers. If pregnant women or primary infant caregivers smoke cigarettes, the home visitor should take action to facilitate the clients in decreasing or quitting tobacco use. The home visitor should refer the pregnant women or primary infant caregivers who smoke to a tobacco cessation program.

The home visitor should do reassessment of tobacco use by pregnant women and primary infant caregivers throughout the clients' enrollment in the PHHV program.

The six ACA MIECHV funded sites will continue to implement their selected home visiting model. In so doing, they are contractual required to address the Improved Maternal and Newborn Health benchmark by decreasing smoking among the primary caregivers and pregnant MIECHV participants.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10	9	9	11	12.5
Annual Indicator	16.3	11.9	13.4	19.5	19.5
Numerator	11	8	9	13	13
Denominator	67574	67074	67302	66724	66724
Data Source		MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and NCHS	MT Office of Vital Statistics and NCHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.5	13.8	13.8	13.8	13.8

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator includes deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2009 census estimates for the population of 15-19 year olds in the state (May 2010 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

a. Last Year's Accomplishments
The Fetal Infant and Child Mortality Review (FICMR) Coordinator continued to support state and community FICMR injury prevention efforts by providing educational meetings/training. The FICMR coordinator continued to serve as a resource via phone, email, or in-person contact. Current journal articles and information related to youth suicide prevention are sent electronically to local FICMR coordinators.

Local FICMR Teams continued to review child deaths and implement community activities related to prevention of youth suicide.

In April of 2011, the FICMR Coordinator attended the National Conference for Child Death Review (CDR) at the Center for Disease Control in Atlanta, GA.

The FICMR Coordinator attended quarterly Emergency Medical Services Council (EMS) Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The FICMR Coordinator was a member of the Western Regional State Child Death Review Coalition which addresses youth suicides. The FICMR coordinator worked with the epidemiology team for statistics related to this type of death.

The FICMR Coordinator continued with trainings and meetings to educate coordinators on how to accurately complete the State of Montana Fetal, Infant and Child Mortality Review Case Report.

FICMR is currently evaluating the use of the CDR reporting tool, with the intention of participating in the National CDR data collection system to better understand youth suicides. The approval from the Maternal and Child Health Coordination (MCHC) supervisor to move forward with this system was the accomplishment of last year's activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribution of educational materials to local FICMR teams		X	X	
2. Meetings with EMSC Advisory and State Injury Prevention Coalition				X
3. Review of suicide deaths to develop prevention activities				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FICMR Program provides technical assistance to communities for development of activities and policies to reduce the rate of youth suicide. This is achieved through 1) partnerships with 28 local coordinators, especially those in counties experiencing higher rates, 2) collaborating with other agencies, such as EMS, to prevent youth suicides, and 3) the development of resources and tools for community education and activities/policies to reduce youth suicides.

Local FICMR Teams continue to review youth suicide and implement community prevention activities. The FICMR Coordinator assists in the sharing of practices and prevention activities to standardize reporting and collaboration.

The FICMR coordinator is a member of the Safe States Alliance, the Western-States Coalition for Child Death Review, the EMS Advisory team, and the State Injury Prevention Coalition. FICMR coordinator attends meetings to discuss prevention campaigns and strategies at the federal, state and local level.
The FICMR coordinator attended a meeting in December 2011, to discuss the life-course perspective and how FICMR can work with several partners to decrease the rate of youth suicides.

Efforts continue for Montana to implement the National CDR reporting system.

Established a coalition with Suicide Prevention Coordinator and the Office of Public Instruction to bring together a state-wide team to target youth suicide through the creation of policies and support for the suicide prevention activities.

c. Plan for the Coming Year
The FICMR Program will continue to provide technical assistance to communities for development of activities and policies to reduce the rate of youth suicide. This will be achieved through 1) partnerships with 28 local coordinators, especially those in counties experiencing higher rates, 2) collaborating with other agencies, such as EMS, to prevent youth suicides, and 3) the development of resources and tools for community education and activities/policies to reduce youth suicides.

Local FICMR Teams will continue to review youth suicides and implement community activities related to prevention of deaths attributed to youth suicides. The FICMR Coordinator will continue to assist in the sharing of practices and prevention activities to standardize reporting and collaboration.

The FICMR coordinator will continue to be an active member of the Safe States Alliance, the Western-States Coalition for Child Death Review, the Emergency Medical Services Council Advisory team, and the State Injury Prevention Coalition. FICMR coordinator will attend meetings to discuss prevention campaigns and strategies at the federal, state and local level.

Montana continues efforts towards implementing the Child Death Review (CDR) Data Reporting system sometime in 2013 to improve national and local data, as well as prevention activities, related to youth suicides.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011

Performance Data					
Annual Performance Objective	91	91	91	75	65
Annual Indicator	86.8	73.0	64.1	87.0	87.0
Numerator	138	108	82	140	140
Denominator	159	148	128	161	161
Data Source		Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	74.7	74.7	74.7	74.7

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, and St. Vincent Healthcare in Billings.

Notes - 2010
Facilities for high-risk deliveries and neonates in the State of Montana
Benefis Health System, Great Falls
Community Medical Center, Missoula
St. Vincent Healthcare, Billings

Notes - 2009
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2009, Montana had three level III facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

a. Last Year's Accomplishments
Home visiting is recognized as an effective intervention to reduce the number of low birth weight babies. FCHB continued to fund 15 Public Health Home Visiting (PHHV) Programs, 14 county and one tribal health departments, which upheld the Montana Initiative for the Abatement of Mortality Act (MCA 50-19-311). The PHHV visitors provided information and referrals to pregnant women to prevent low birth weight. The PHHV home visitors also assisted clients to enter into early and continuous prenatal care.

The PHHV Nurse Consultant supported state and community PHHV efforts as a resource via

phone, email or in-person contact. Links to training and information related to pre-term labor prevention were shared with PHHV home visitors.

PHHV sites were visited at least once a year by the PHHV Nurse Consultant. The sites were monitored for their compliance with program requirements and the FCHB staff provided technical assistance as needed. Site visit quality assurance forms included chart review to monitor the appropriateness of referrals.

PHHV visitors distributed materials on detection of pre-term labor to pregnant women. Women are then empowered to fully participate in medical prenatal care by contacting the provider if signs of preterm labor occur.

In FY 2011, the Lake County Health Department was awarded ACA Maternal, Infant Early Childhood Home Visiting (MIECHV) Program funds to implement the Parents As Teachers (PAT) model. A contractual requirement was to address the ACA MIECHV benchmark/construct performance measures, which includes referring all MIECHV clients to appropriate health care providers and ensuring that they have health insurance. It is anticipated that over the life of the MIECHV funding, the data will verify that Lake County met this performance measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The PHHV Nurse Consultant supported state and community PHHV efforts as a resource via phone, email or in-person contact.				X
2. Links to training and information related to pre-term labor prevention were shared with PHHV home visitors.				X
3. FCHB upheld the Montana Initiative for the Abatement of Mortality Act (MCA 50-19-311) and provided information and referrals to pregnant women to prevent low birth weight.		X	X	
4. The PHHV home visitors assist clients to enter into early and continuous prenatal care		X	X	
5. PHHV sites were visited and monitored by a PHHV Nurse Consultant.				X
6. PHHV visitors distributed materials on detection of pre-term labor to pregnant women.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities

Both PHHV and MIECHV home visiting programs assess for and intervene to prevent low birth weight.

Montana administered funding to 14 local and one tribal health departments for PHHV home visiting services. The PHHV contracts require the PHHV site visitors to assess pregnant women for the risk of delivering a low birth weight infant and provide referrals and other resources to minimize the risk.

The ACA MIECHV funds continue to provide funds to additional counties for home visiting services. Lake County was joined by Lincoln, Mineral and Flathead County Health Departments for implementing PAT and Yellowstone and Missoula are implementing Nurse Family Partnership

(NFP). ACA MIECHV requires data collection on the outcomes of the referrals; therefore, data will be forthcoming to judge MIECHV funding impact in MT. See the map for NPM 15, Current Activities.

DPHHS will continue to partner with agencies such as the March of Dimes, to alert the public of the need to avert low birth weight infant deliveries. MT joined 43 other states in addressing the ASTHO's President Challenge to improve birth outcomes by reducing infant mortality and prematurity by 8%.

c. Plan for the Coming Year

During the coming year, the contract in effect between the DPHHS/FCHB and the local Public Health Home Visiting (PHHV sites) will be continued with the same activities as the SFY 2012 contract being carried out by the contractors. The home visitors in the fifteen contracted sites will be expected to assess the risk of each pregnant woman to deliver an infant of low birth weight. If a pregnant woman is at risk of delivering a low birth weight infant, the home visitor should take action to facilitate the clients being transferred to a facility prepared for high-risk deliveries and intervening with low weight infants. The home visitor should coordinate with the pregnant women's' pregnancy managers. The home visitor should do reassessment of risk of delivery of a low birth weight infant to pregnant clients throughout the clients' enrollment in the PHHV program.

The six ACA MIECHV funded sites will continue to implement their selected home visiting model. In so doing, they are contractual required to address the Improved Maternal and Newborn Health benchmark of prenatal care. The contractors are expected to refer women with no healthcare provider to an appropriate source and to assist those with a healthcare provider to maintain that relationship. The ACA sites are required to increase or maintain the percent of clients with health insurance.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	85.9	84.5	73	74	75
Annual Indicator	82.1	71.3	73.1	70.9	70.9
Numerator	10213	8982	8061	8554	8554
Denominator	12437	12595	11029	12058	12058
Data Source		Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75	75	75	75

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. 10% of births had unknown timing of prenatal care initiation. The "unknowns" are not included in the denominator. A new birth record format was implemented in 2008, which changed the way the timing of prenatal care initiation was calculated. Thus, the measure for 2008 and onward may not be comparable to previous years.

a. Last Year's Accomplishments
The FCHB funded 15 Public Health Home Visiting (PHHV) programs, 14 county and one tribal health departments, with state funds. Each contractor's PHHV home visitor assessed and monitored the status of prenatal care during home visits and other face-to-face contacts with PHHV clients and promoted the importance of early and adequate prenatal care to pregnant women and women of childbearing age in Montana. PHHV home visitors provided the PHHV clients with education on the importance of starting prenatal care as early as possible and continuing throughout the pregnancy.

The FCHB collaborated with local public health providers, physicians, March of Dimes, Family Planning Programs, and other MCH partners on issues surrounding delivery of very low birth weight infants and counseled and referred clients with positive pregnancy tests to health care resources.

PHHV pregnant clients without health insurance coverage are assisted by PHHV home visitors with the presumptive eligibility process for Medicaid, thus facilitating access to early prenatal care and other healthcare resources.

In FY 2011, the Lake County Health Department was awarded ACA Maternal, Infant Early Childhood Home Visiting (MIECHV) Program funds to implement the Parents As Teachers (PAT) model. A contractual requirement was to address the ACA MIECHV benchmark/construct performance measure: Improved maternal and newborn health. MT's MIECHV contractor(s) will be required to collect data on: these three of eight constructs: prenatal care, preconception care, and maternal and child health insurance status.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The PHHV Nurse Consultant supported state and community PHHV efforts via phone, email or in-person contacts. Current information related to the importance of early prenatal care is provided to PHHV home visitors.				X
2. The FCHB funded 15 PHHV programs which provide home visiting services to high risk pregnant women to promote healthy pregnancy outcomes.		X	X	
3. The PHHV home visitors assessed and monitored the status of prenatal care during home visits and other face-to-face contacts with PHHV clients and promoted the importance of early and adequate prenatal care to pregnant women and women of childbearing		X	X	X
4. The FCHB collaborated with local public health providers, physicians, March of Dimes, Family Planning Programs, and other MCH partners on issues surrounding delivery of very low birth weight infants and counseled and referred clients with positive pr			X	X
5. PHHV pregnant clients are assisted with the presumptive eligibility process for Medicaid.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Montana MIECHV Updated State Plan included this state-wide goal: "Identify and provide comprehensive services to improve outcomes for families who reside in at risk communities" and the objective is stated: "Increase the number of pregnant women who receive prenatal care in the first trimester."

In July 2012, Lincoln, Mineral and Flathead County Health Departments, implementing PAT and Yellowstone and Missoula, implementing Nurse Family Partnership (NFP), joined Lake as ACA MIECHV funded sites. These sites are charged with increasing the number of pregnant women who receive prenatal care in the first trimester." See the attachment for NPM 15, Current Activities.

Montana DPHHS will continue to fund the 15 PHHV sites for home visiting. The fifteen sites are a continuation of the Montana Initiative for Abatement of Mortality in Infant (MIAMI (MCA) 50-19-311)) project in existence since 1989. One of the services to be provided is "…assistance to low-income women and infants in gaining access to prenatal care…" so the contracts with local health departments have and will continue to have reference to MIAMI home visitors promoting early continuous prenatal care.

c. Plan for the Coming Year

During the coming year, the contract in effect between the DPHHS/FCHB and the local Public Health Home Visiting (PHHV sites) will be continued with the same activities as the SFY 2012 contract being carried out by the contractors. The home visitors in the fifteen contracted sites will be expected to facilitate pregnant women in receiving early and continuous prenatal care. If a pregnant woman has no pregnancy health care provider, the home visitor should take action to facilitate the client becoming enrolled with one. Home visitors can ensure women have presumptive eligibility for prenatal care in the Medicaid program. The home visitor should do reassessment of pregnant clients throughout the clients' enrollment in the PHHV program to

monitor prenatal medical care participation.

The six ACA MIECHV funded sites will continue to implement their selected home visiting model. In so doing, they are contractual required to address the Improved Maternal and Newborn Health benchmark, which includes prenatal care, preconception care, and maternal and child health insurance status.

D. State Performance Measures

State Performance Measure 1: *The percent of children with cleft lip and/or palate receiving care in interdisciplinary clinics.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					90
Annual Indicator				89.7	90.0
Numerator				26	18
Denominator				29	20
Data Source				CSHCN Program-CHRIS system	CSHCN Program
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	90	90

Notes - 2011
The data reflect the number of infants born during FFY 2011 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

Notes - 2010
Data are for federal fiscal year (FFY) 2010. The data reflect the number of infants born during FFY 2010 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

a. Last Year's Accomplishments
FFY clinic attendance indicated a slight decrease in attendance from the previous year. The teams continue to work on issues of clinic attendance with the premise that all children with cleft/craniofacial conditions benefit from team care. 61% of the cleft clinic population is covered by Medicaid, indicating these families are more likely to have financial difficulties which prevent them from participating in clinic, including the cost of gas, understanding the Medicaid travel payment system, or having reliable transportation to travel. Families have listed all of these issues. Additional Regional Pediatric Specialty Clinic (RPSC) staff allowed for more pre-clinic contact with families, which has resulted in better clinic utilization.
CSHS distributed the Montana "Cleft Lip and Cleft Palate" Fact Sheet to the RPSC sites, at conferences and trainings, and to hospital nurseries. The Fact Sheet includes a link to one family's journey which began with the birth of their child with a bilateral cleft through her early treatment.
CSHS continues to work to improve the quality of care provided through team clinics. An important goal of Montana's Cleft/craniofacial team is that children born with cleft palate or cleft lip and palate will enter school with speech that is adequate for classroom participation and peer

acceptance. The speech assessment pilot study which was completed in June of 2010 was presented to team members and the RPSC staff for feedback during FFY 2011. The study demonstrated that cleft clinic speech assessment documentation is not adequate to evaluate surgical results, although it was reassuring to know that with limited documentation, over half of children with palate repairs had age-appropriate to mild impairment of speech intelligibility upon entering school. The need for an additional non-biased study completed by a speech language pathologist was identified. The results of the study indicated a need for more consistent reporting of clinic speech assessments.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Clinic teams worked on clinic attendance issues to assure team care is offered to all newborns with cleft/craniofacial conditions.	X			
2. CSHS distributed the Montana "Cleft Lip and Cleft Palate" Fact Sheet to the regioal clinic sites, at conferences and trainings, and to hospital nurseries.			X	X
3. Results of the speech assessment pilot study were presented to team members and regional clinic staff for feedback				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FFY 2011 Montana held 19 Cleft/craniofacial team clinics in 8 locations around the state with an attendance rate of 53% which is slightly less than the attendance rate for FFY 2010. Attendance rates are higher in FFY 2012 at 56% with partial year data.

CSHS conducted a well-received Part I of Cleft/craniofacial Treatment training for Regional Pediatric Specialty Clinic (RPSC) staff as well as speech pathologists. Part II will be conducted in July of 2012. Tools for ongoing speech assessments will be disseminated to clinic coordinators and speech therapists beginning in July 2012. These trainings emphasize a team approach to care as well as providing information about referral resources.

A family/team contract is being developed to assist families with understanding their role in supporting their child's care. This contract promotes comprehensive treatment for children with clefts from infancy to adulthood with an emphasis on a team care approach which includes: the importance of timely intervention for ear infections; speech and language development; the timing of surgical intervention; dental care and the coordination of orthodontia, as well as psycho-social issues for this population.

c. Plan for the Coming Year

Montana plans to continue to offer clinics at the 3 Regional Pediatric Specialty Clinics (RPSC) and 5 outreach locations around the state. There are no plans to add additional clinic locations at this time. RPSC staff will be focusing on increasing clinic attendance by increasing family involvement in decision making and increasing their understanding of the importance of ongoing team clinic attendance. Implementation of the family/team contract will be continued and offered to families. The teams will focus on providing the contract to parents of newborns, infants, and

toddlers initially.
As part of ongoing American Cleft Palate Association team certification approval, a formal speech outcome study is under consideration depending on staff resources. This study will be conducted with assistance from the MCH epidemiologist, in conjunction with the State's two craniofacial surgeons who staff the Cleft/craniofacial Team Clinics.
CSHS will continue to bill for Cleft/craniofacial Team Clinics and use the revenue to support the clinics, and purchase supplies such as toothbrushes, feeders, brochures and handouts for children/families with Cleft/craniofacial conditions.
Models of extended care coordination through RPSC staff for the Cleft/craniofacial population will be explored during the coming year. The care for children with cleft/craniofacial conditions involves sequential treatment provided by multiple professionals and programs. Coordinating this care can be complex and time consuming for families. With RPSC staff assistance, care coordination can be extended to the community level and will promote healthy outcomes for children with Cleft/craniofacial conditions.

State Performance Measure 2: *The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					1
Annual Indicator				24.4	38.7
Numerator				10386	13101
Denominator				42631	33813
Data Source				Medicaid	Medicaid
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	30	30	30	30	30

Notes - 2011
Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2010 through June 30, 2011 (SFFY 2011). Data include children who received an oral evaluation by a dentist.

NOTE: The 2011 indicator of 1 is an error and per the HRSA Call Center, it can not be corrected for the 9/12 submission. The 2011 indicator should have been 30, as it is for 2012 through 2016.

Notes - 2010
Data are from the Montana Medicaid Program (Healthy Montana Kids Plus) and include all children enrolled in Medicaid during July 1, 2009 through June 30, 2010 (State Fiscal Year 2010) who received an oral evaluation by a dentist.

a. Last Year's Accomplishments
State Performance Measure 02 addresses Montana's MCH Priority Area of children's oral health which falls under the Public Health and Safety Division's (PHSD) Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

The state Oral Health Program worked with the state Medicaid office to improve the oral health of Medicaid clients 0 through 6 years of age. In addition to monitoring Medicaid data, the state Oral Health Program added two questions to the Behavioral Risk Factor Survey (BRFSS) pertaining to oral health. These questions will allow more insight into the availability and access to dental care for a broader range of Montanans.

All available data was reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families.

The oral health program worked closely with Head Start programs to disseminate information on dental resources at the state and local level.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All available data will be reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families				X
2. work closely with Head Start programs to disseminate information on dental resources at the state and local level			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The state Oral Health Program is working with the state Medicaid office to improve the oral health of Medicaid clients 0 through 6 years of age.

All available data will be reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families.

The state oral health program is also working closely with Head Start programs across the state to standardize the dental exam forms, collect more state-level data and promote establishing a dental home for all children enrolled in Head Start programs.

c. Plan for the Coming Year
The PHSD is exploring possibile implementation of a fluoride varnish program for high-risk communities, in which primary medical providers and clinical staff will be trained to perform oral assessments, provide fluoride treatments, and help find dental homes for children 0 through 6 years of age. Clients and their families will be referred by physicians to the Medicaid care coordination program for help in locating a dental home.

State Performance Measure 3: *The percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective					12
Annual Indicator			10.9	8.0	8.0
Numerator			11	10	10
Denominator			101	125	125
Data Source			Linked Medicaid-birth certificate data.	Linked Medicaid-birth certificate data.	Linked Medicaid-birth certificate data.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12	12	12	12	12

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012. Data source are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers, and YEARFIRST to YEARMAX, With Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

Notes - 2010
FOOTNOTE1 'MONTANA OFFICE OF VITAL STATISTICS, MONTANA MEDICAID INFORMATION SYSTEMS';

FOOTNOTE2 "Montana Occurrent Births To Montana Resident Mothers, &YEARFIRST to &YEARMAX, With Gestational Diabetes Indicated";

FOOTNOTE3 'Medicaid Claims Data With CPT codes: 82947, 82962, 82950, 82951, 83036, 82952';

FOOTNOTE4 "Linked Within 42 And 180 Days Of Birth On Mother's Birthdate and Mother's Maiden Name, Infants Last Name or Father's Name To Recipient's Last Name";

a. Last Year's Accomplishments
State Performance Measure 03: addresses Montana's MCH Priority Area of maternal health which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

All available data were reviewed and used to direct discussions within the Public Health and Safety Division (PHSD) regarding improved follow up care and health education services for Medicaid clients with gestational diabetes.

In 2010, there were 10 births with follow up care out of 125 gestational diabetes births.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Data were reviewed and used to direct discussions to improve follow up care				X
2.				

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family and Community Health Bureau (FCHB), Office of Epidemiology and Scientific and Support (OESS), Medicaid, and the Montana Cardiovascular Disease and Diabetes Prevention Program of the Chronic Disease Prevention and Health Promotion Bureau will collaborate to promote improved follow up care and health education services for Medicaid clients with gestational diabetes mellitus (GDM). This collaboration will also improve state-level data collection and reporting for Medicaid clients with gestational diabetes.

c. Plan for the Coming Year

A possible intervention which the PHSD may undertake is to work with Medicaid data to track birth records for Medicaid clients with GDM. As soon as a follow up visit is filed for the client with GDM, the Medicaid office will notify the OESS as to where the client is receiving follow up care. The Montana Diabetes Program (MDP) and OESS will prepare and send a letter from the state medical officer to the provider of care for the client. This letter will notify the provider that this client recently had GDM and will also provide a reminder that this client needs to have her blood glucose measured within six weeks to six months postpartum. In addition, the provider will be informed of any available lifestyle intervention programs to which clients may be referred. Program information, locations and contact information are available to providers through a printed brochure or the website:
http://www.dphhs.mt.gov/PHSD/Diabetes/DiabetesPrevention.shtml.
Medicaid claims data will be used to track whether targeted women have a blood glucose evaluation within the designated timeframe.

State Performance Measure 4: *The rate of death to children 0 through 17 years of age caused by unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					13
Annual Indicator			13.6	21.9	21.9
Numerator			30	49	49
Denominator			219828	223563	223563
Data Source			Death certificate data	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	13	12	12	12	12

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Notes - 2010
Data Source: MT Office of Vital Statistics & NCHS

Notes - 2009
Includes deaths to children 1 through 17 years of age with ICD10 causes V01-X59 and Y85-Y86.

a. Last Year's Accomplishments
The Fetal Infant and Child Mortality Review (FICMR) Coordinator continued to support state and community injury prevention efforts by providing educational meetings/trainings and continued to be a resource via phone, email or through in-person contact and shares prevention information with local coordinators. Current journal articles and information related to infant and child death prevention, unintentional injuries and death due to motor vehicle crashes, falls, drowning, unsafe sleep conditions, and poisoning are disseminated to the local FICMR coordinators and state partners.

In the Fall of 2011, local FICMR coordinators met with the state coordinator to discuss the program and identify areas of improvement prevention of deaths due to unintentional injuries. The local FICMR Teams continued to review child deaths and implement community activities related to prevention of child deaths due to unintentional injuries.

In April of 2011, the FICMR Coordinator attended the National Conference for Child Death Review (CDR) at the Center for Disease Control in Atlanta, GA.

The FICMR Coordinator attended quarterly Emergency Medical Services Council (EMS) Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The FICMR Coordinator was a member of the Western Regional State Child Death Review Coalition which addresses deaths of children 0 through 17 years of age caused by unintentional injuries.
The FICMR coordinator worked with the epidemiology team for statistics related to this type of death.

The FICMR Coordinator continued with trainings and meetings to educate coordinators on how to accurately complete the State of Montana Fetal, Child and Infant Mortality Review Case Report.

FICMR is currently evaluating the use of the CDR reporting tool, with the intention of participating in the National CDR data collection system to better understand child deaths, including those caused by unintentional injury. The approval from the Maternal and Child Health Coordination (MCHC) supervisor to move forward with this system was the accomplishment of last year's activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Education/Trainings in prevention and FICMR reviews		X	X	
2. Meeting with Coalitions and collaborating with state and local prevention groups.		X	X	X

3. Continuing effort to implementation of the National CDR database for MT				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FICMR Program provides technical assistance to communities for development of activities and policies to reduce the rate of motor vehicle deaths to children. This is achieved through 1) partnerships with 28 local coordinators, especially those in counties experiencing higher rates, 2) collaborating with other agencies, such as EMS, to prevent unintentional injury deaths, and 3) the development of resources and tools for community education and activities/policies to reduce unintentional injury deaths.

Local FICMR Teams continue to review child deaths and implement community activities related to prevention of deaths attributed to unintentional injuries. The FICMR Coordinator assists in the sharing of practices and prevention activities to standardize reporting and collaboration.

The FICMR coordinator is a member of the Safe States Alliance, the Western-States Coalition for Child Death Review, the EMS Advisory team, and the State Injury Prevention Coalition. FICMR coordinator attends meetings as scheduled to discuss prevention campaigns and strategies at the federal, state and local level.

The FICMR coordinator attended a meeting in December 2011, to discuss the life-course perspective and how FICMR can work with several partners to decrease the rate of child deaths. Efforts continue for Montana to implement the National CDR reporting system.

c. Plan for the Coming Year
The FICMR Program will continue to support community and state efforts in targeting the rate of deaths to children aged 14 and younger caused by motor vehicle crashes. The plan to target the rate of deaths caused by unintentional injury to 1) work collaboratively with 28 local coordinators, especially those in counties experiencing higher rates, 2) work collaboratively with other agencies to target unintentional injury deaths and 3) development of resources and tools for community education and activities/policies to reduce unintentional injury deaths.

Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of deaths attributed to unintentional injuries. The FICMR Coordinator will continue to assist in the sharing of practices and prevention activities to standardize reporting and collaboration.

The FICMR coordinator will continue to be an active member of the Safe States Alliance, the Western-States Coalition for Child Death Review, the Emergency Medical Services Council Advisory team, and the State Injury Prevention Coalition. FICMR coordinator will attend meetings to discuss prevention campaigns and strategies at the federal, state and local level.

Montana continues efforts towards implementing the Child Death Review (CDR) Data Reporting system sometime in 2013 to improve national and local data, as well as prevention activities, related to child deaths due to unintentional injuries.

The FICMR program will continue to partner with community and state organizations to address unintentional injury prevention education and activities related to motor vehicle crashes, falls, drowning, unsafe sleep conditions, and poisoning.

State Performance Measure 5: *The precent of women who smoke during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					15
Annual Indicator			16.0	16.3	16.3
Numerator			1949	1954	1954
Denominator			12158	11991	11991
Data Source			Birth certificates	Birth certificates	Birth certificates
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15	14	14	14	14

Notes - 2011
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Notes - 2010
Data for 2010 were not available at the time of grant submission. Data will be updated when 2010 birth data are final.

Notes - 2009
Women with "unknown" reported for smoking during pregnancy (1% of resident live births) are not included in the denominator.

a. Last Year's Accomplishments
Contracts in effect between DPHHS and 15 Public Health Home Visiting (PHHV) sites contained the following wording: The Contractor agrees to provide the following services for the purposes of addressing the following outcomes: (1) Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 2) For each high risk pregnant woman (HRPW)/PHHV client the following required, standardized screening will be administered and the results will be entered into the client's PHHV/HDIS electronic record: The U.S. Preventive Services Task Force (USPSTF) Tobacco Cessation Counseling Guide sheet at USPSTF least at intake for the HRPW and high-risk infant (HRI). The Tobacco Cessation Counseling Guide sheet assessment tool is located at:
http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm

Using state moneys, the FCHB funded 15 PHHV programs, 14 county and one tribal health departments, which promoted the Montana Tobacco Useage Prevention Program (MTUPP) Quit Line through information and referrals for their pregnant women and infant/family units. The PHHV home visitors also referred clients to other community cessation programs.

PHHV sites began entering PHHV client data elements into a common electronic data system as of 1 July 2009 and have continued to use the data system. Data on outcomes related to pregnant women smoking, other tobacco use, cessation and referrals to cessation resources are collected by all of the PHHV sites. The data is analyzed by OESS and feedback provided to the PHHV contractors for their quality improvement efforts.

The PHHV Nurse Consultant conducted site reviews at the 15 sites. For quality feedback purposes, the findings for each site are consolidated and a report is given to each site. Each site can evaluate whether or not women identified as smokers were referred for help with decreasing smoking and whether or not the women reported having smoked during the last three months of pregnancy or having quit smoking during the pregnancy.

In FY 2011, the Lake County Health Department was awarded ACA Maternal, Infant Early Childhood Home Visiting (MIECHV) Program funds to implement the Parents As Teachers (PAT) model. A contractual requirement was to address the ACA MIECHV benchmark/construct performance measure: Decrease smoking among primary caregivers and pregnant MIECHV participants. It is anticipated that over the life of the MIECHV funding, the data will verify that Lake County met this performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Home visitors followed The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet at intake of clients to assess tobacco use and plan intervention for those who use tobacco.		X	X	X
2. Funded 15 PHHV programs which promoted and referred clients to the MT Tobacco Quit Line and provided cessation information to clients		X	X	
3. MIECHV funds awarded to Lake County for implementing PAT and contractually required to address the ACA MIECHV benchmark to reduce smoking. Cessation information and referrals were provided to PAT clients.		X	X	
4. PHHV consultant conducted site reviews and completed feedback report on site's contractually obligation to address smoking cessation.		X	X	X
5. PHHV client data elements are entered by each site into a common electronic data system and the data is analyzed for reporting and quality improvement purposes.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 15 PHHV programs assess tobacco use and intervene with adults who smoke in situations where fetuses and children may be compromised by using the U.S. Preventive Services Task Force Tobacco Cessation Counseling (USPTF) Go to http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm. The PHHV Nurse consultant conducts chart reviews during the site visit to ensure that contract compliance. If the client is using tobacco, the home visitor follows the USPTF guide to assist the client in decreasing tobacco use, which oftentimes is a referral to MTUPP or other DPHHS sponsored tobacco use control programs located throughout the state.

The ACA MIECHV funds continue to provide funds to additional counties for home visiting services. Lake County was joined by Lincoln, Mineral and Flathead County Health Departments for implementing PAT and Yellowstone and Missoula are implementing Nurse Family Partnership

(NFP). See the attachment for NPM 15.

ACA MIECHV funds require collection of data on quantifiable, measurable use of tobacco. Improvement is defined as rate decreases over time. Each site is collecting data related smoking in the pregnant women and caregivers. Tobacco usage by pregnant women will be measured pre- and post-natally with an expected outcome of reduction of smoking by the cohort over time.

c. Plan for the Coming Year

During the coming year, the contract in effect between the DPHHS/FCHB and the local Public Health Home Visiting (PHHV sites) will be continued with the same activities as the SFY 2012 contract being carried out by the contractors. The home visitors in the fifteen contracted sites will be expected to assess tobacco use of each pregnant women and primary infant caregivers. If pregnant women or primary infant caregivers smoke cigarettes, the home visitor should take action to facilitate the clients in decreasing or quitting tobacco use. The home visitor should refer the pregnant women or primary infant caregivers who smoke to a tobacco cessation program.

The home visitor should do reassessment of tobacco use by pregnant women and primary infant caregivers throughout the clients' enrollment in the PHHV program.

The six ACA MIECHV funded sites will continue to implement their selected home visiting model. In so doing, they are contractual required to address the Improved Maternal and Newborn Health benchmark by decreasing smoking among the primary caregivers and pregnant MIECHV participants.

State Performance Measure 6: *The percent of children 19-35 months of age who have received the 4th immunization in the diphtheria, tetanus, and pertussis (DTaP) series.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					80
Annual Indicator		74.4	76	76.6	82.6
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	80	80	80	80

Notes - 2011

The source of data is the National Immunization Survey (NIS), Q3/2010-Q2/2011. The confidence interval for this indicator is +/- 5.1. The data for 2011 are not yet final.

Notes - 2010
Data are from the National Immunization Survey. The confidence interval is +/-6.2. The data are final for 2010.

Notes - 2009
Data are from the 2009 National Immunization Survey. The confidence interval is +/-6.5.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health (MCH) Needs Assessment process resulted in the creation of a new state performance measure to address immunizations against Diphtheria, Tetanus, and Pertussis. The new state performance measure will be MT State Performance Measure (SPM) 06: the percent of children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

State Performance Measure 06 addresses Montana's MCH Priority Area of Immunizations which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis and other vaccine preventable conditions."

The Montana Department of Public Health and Human Services (DPHHS) Immunization Program continued to encourage and support vaccination activities throughout the state, including:
1. Replacement of the Immunization Information System (IIS) with a modernized IIS which meets all 12 National Vaccine Advisory Council functional standards for an IIS.
2. Enforcement of child care and school entry immunization requirements through contracts with local health departments.
3. Increased collaboration between WIC programs and Immunization Programs, through contracts with local health departments, to review immunization records for WIC program participants.
4. Increased collaboration between local health departments and private providers in each jurisdiction to implement best practices and increase immunization rates.
5. Provided Quarterly Reports to all Vaccines for Children Providers, to be used for quality improvement purposes, enabling them to identify and recall children who were missing or coming due for immunizations.
6. Encouraged testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of positive test results to state or local health departments for case management and follow up.

The Family and Community Health Bureau (FCHB) which houses the Maternal and Child Health (MCH) Coordination Section provided technical assistance and programmatic support to local health departments which selected State Performance Measure (SPM) 06 as the focus for their Title V funds.
In SFY 2012, the following four counties selected SPM 06 and conducted activities to help improve immunization rates in their counties.

- Golden Valley
- Granite
- Ravalli
- Wheatland

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Replaced the Immunization Information System (IIS) with a modernized IIS which meets all 12 National Vaccine Advisory Council functional standards				X
2. Enforcement of child care and school entry immunization requirements		X	X	
3. Increased collaboration between WIC programs and Immunization Programs, through contracts with local health departments,				X
4. Increased collaboration between local health departments and private providers in each jurisdiction to implement best practices and increase immunization rates.			X	X
5. Provided Quarterly Reports to all Vaccines for Children Providers, to be used for quality improvement purposes,		X	X	X
6. Encouraged testing of all pregnant women for Hepatitis B infection during every pregnancy		X	X	
7. Provided technical assistance and programmatic support to local health departments				X
8.				
9.				
10.				

b. Current Activities
The FCHB promoted an Immunization Activity Guide for local health departments to provide them with best practices to improve immunization rates in their counties. See NPM 7.

The Public Health Home Visiting (PHHV) program will assess whether infants in the program receive their two, four and six month immunizations and the PHHV provider will counsel parents on the importance of continuing scheduled immunizations for infants.

The MIECHV funding supported Parents as Teachers (PAT) implementation and continuation by the Lake County Health Department. Families enrolled in PAT are educated regarding immunizations and health concerns.

The Children's Special Health Services section will assess the immunization status of children who attend eight of the Cleft Clinic sites and provide referrals as necessary to the appropriate resources for immunization services.
The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS Immunization Section will partner with 53 contractors to improve the immunization rates in MT. The Immunization Section has monthly phone calls with all local health department partners to provide technical assistance and programmatic support

c. Plan for the Coming Year
The Maternal, Infant, Early Childhood Home Visiting (MIECHV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive age-appropriate immunizations. The MIECHV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

MIECHV funding will continue to fund Parents as Teachers (PAT) in Lake County and is also supporting PAT in Mineral, Flathead, and Lincoln Counties and Nurse Family Partnership (NFP) is being implemented in Yellowstone and Missoula Counties. Families enrolled in PAT are

educated regarding immunizations and health concerns.

The Children's Special Health Services section will assess the immunization status of children who attend eight of the Cleft Clinic sites and provide referrals as necessary to the appropriate resources for immunization services.
The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization information system.
• Providing outreach and referrals for children identified by immunization information systems who are missing or coming due for immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

State Performance Measure 7: *The percent of children 19-35 months of age who have received an immunization against varicella.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					82
Annual Indicator		77.7	77.5	80.6	85.7
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Is the Data Provisional or				Final	Provisional

Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	82	83	83	83	83

Notes - 2011
Data are from the Q3/2010-Q2/2011, NIS. The confidence interval is +/- 4.4. The data are provisional.

Notes - 2010
Data are from the National Immunization Survey tables. The confidence interval is +/-5.9. Data is final for 2010.

Notes - 2009
Data are from the 2009 National Immunization Survey. The confidence interval is +/-6.6.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address immunizations against Varicella. The new state performance measure will be MT State Performance Measure (SPM) 07: the percent of children 19-35 months of age who have received all age-appropriate immunizations against Varicella.

State Performance Measure 07 addresses Montana's MCH Priority Area of Immunizations which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis and other vaccine preventable conditions."

The Montana Department of Public Health and Human Services (DPHHS) Immunization Program continued to encourage and support vaccination activities throughout the state, including:
1. Replacement of the Immunization Information System (IIS) with a modernized IIS which meets all 12 National Vaccine Advisory Council functional standards for an IIS.
2. Enforcement of child care and school entry immunization requirements through contracts with local health departments.
3. Increased collaboration between WIC programs and Immunization Programs, through contracts with local health departments, to review immunization records for WIC program participants.
4. Increased collaboration between local health departments and private providers in each jurisdiction to implement best practices and increase immunization rates.
5. Provided Quarterly Reports to all Vaccines for Children Providers, to be used for quality improvement purposes, enabling them to identify and recall children who were missing or coming due for immunizations.
6. Encouraged testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of positive test results to state or local health departments for case management and follow up.

The Family and Community Health Bureau (FCHB) which houses the Maternal and Child Health (MCH) Coordination Section provided technical assistance and programmatic support to local health departments which selected National Performance Measure (NPM) 07 as the focus for their Title V funds.

In SFY 2012, the following one county selected SPM 07 and conducted activities to help improve immunization rates in its county.

- Broadwater

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Replacement of the Immunization Information System (IIS) with a modernized IIS which meets all 12 National Vaccine Advisory Council functional standards				X
2. Enforcement of child care and school entry immunization requirements		X	X	
3. Increased collaboration between WIC programs and Immunization Programs, through contracts with local health departments,				X
4. Increased collaboration between local health departments and private providers in each jurisdiction to implement best practices and increase immunization rates.			X	X
5. Provided Quarterly Reports to all Vaccines for Children Providers, to be used for quality improvement purposes,		X	X	X
6. Encouraged testing of all pregnant women for Hepatitis B infection during every pregnancy		X	X	
7. Provided technical assistance and programmatic support to local health departments				X
8.				
9.				
10.				

b. Current Activities

The FCHB developed an Immunization Activity Guide for local health departments to provide them with best practices to improve immunization rates in their counties. See NPM 7.

The Public Health Home Visiting (PHHV) program will assess whether infants in the program receive their two, four and six month immunizations and the PHHV provider will counsel parents on the importance of continuing scheduled immunizations for infants.

The MIECHV funding supported Parents as Teachers (PAT) implementation and continuation by the Lake County Health Department. Families enrolled in PAT are educated regarding immunizations and health concerns.

The Children's Special Health Services section will assess the immunization status of children who attend eight of the Cleft Clinic sites and provide referrals as necessary to the appropriate resources for immunization services.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS Immunization Section will partner with 53 contractors to improve the immunization rates in MT. The Immunization Section has monthly phone calls with all local health department partners to provide technical assistance and programmatic support.

c. Plan for the Coming Year

The Maternal, Infant, Early Childhood Home Visiting (MIECHV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive age-appropriate immunizations. The MIECHV and state PHHV providers will counsel parents on the importance

of continuing scheduled immunizations for infants.

MIECHV funding will continue to fund Parents as Teachers (PAT) in Lake County and is also supporting PAT in Mineral, Flathead, and Lincoln Counties and Nurse Family Partnership (NFP) is being implemented in Yellowstone and Missoula Counties. Families enrolled in PAT are educated regarding immunizations and health concerns.

The Children's Special Health Services section will assess the immunization status of children who attend eight of the Cleft Clinic sites and provide referrals as necessary to the appropriate resources for immunization services.
The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization information system.
• Providing outreach and referrals for children identified by immunization information systems who are missing or coming due for immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

E. Health Status Indicators

The Health Status Indicators (HSIs) provide a description and overview of the resident Montana population. They are an opportunity for the state to review and consider the current rates and trends for crucial maternal and child health (MCH) issues, such as low birth weight, very low birth weight, and deaths due to various causes.

The FICMR Program recently hired a new FICMR State Coordinator who brought to the position over 5 years of public health experience, most recently as a program coordinator in the Division's Immunization Section. In 2011, the FICMR Coordinator's focus was shifted to working on the state's MIECHV grants; Hiring constraints did not permit the hiring of MIECHV staff until the spring of 2012.
It should be noted that unintentional injury and motor vehicle deaths are a leading cause of death

for Montanans of all ages, not just children and youth. The Local FICMR Teams 2005-2006 data analysis, indicated that at least 90% of unintentional injury deaths to children aged 14 years and younger and 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the unintentional injuries and deaths are similar and include alcohol or drug use by a caregiver, poor or inadequate supervision; lack of use of available safety measures such as seatbelts, child safety seat use or helmets; inattentive and reckless driving, and driver's experience.

The State FICMR Coordinator, whose first day was June 18, 2012, has begun working with the OESS on analyzing the Local FICMR teams' case report data for the years of 2007 to 2010. The goal is to publish a FICMR report that identifies the preventable deaths and unintentional injuries and provides injury and death prevention educational activities that can be implemented by the local FICMR teams. It is hoped that the FICMR report will be a useful tool at the 2013 Legislative Session in support of passing a primary seatbelt law (not currently passed in MT) and be used for public service announcements. Additionally, the State FICMR Coordinator has already begun partnering with the State Injury Prevention Coordinator on educating their respective contractors and partners on doable prevention activities.

The ACA Maternal Infant Early Childhood Home Visiting Program (MIECHV) is viewed as a viable tool for addressing the low birth weight HSIs. Four county health departments are in various stages of implementing Parents As Teachers and two are implementing Nurse Family Partnership. Additionally, MT has joined 43 other states in addressing the ASTHO's President Challenge to improve birth outcomes by reducing infant mortality and prematurity by 8%.

As explained in detail in the Public Input section, the Public Health and Safety Division is developing the MT State Health Improvement Plan. The Plan includes the goal areas of 1) Reduce Tobacco Use; 2) Reduce Injuries and Environmental Health Hazards; and 3) Promote maternal and child health. It is anticipated that the Plan will include action steps aimed at addressing these HSIs.

F. Other Program Activities

The health of the maternal and child health population, which encompasses women of childbearing age (15-44 years of age), including pregnant women, infants, children, youth, (including those with special health care needs) and their families, is of critical importance to the state and nation. Infants and children deserve excellent health services, and the Family and Community Health Bureau (FCHB) has a major role in ensuring that those services are available and accessible through the Title V MCH Block Grant Program. The FCHB also recognizes that education is intrinsically related to public health, and that a truly healthy population is one that is prepared to assess its own needs and plan accordingly. Education and health services work hand-in-hand to improve the lives of all Montanans.

Montana's 2011 MCH Block Grant application provides a look at how the FCHB, through partnerships with public and private organizations will strive to meet the needs of the MCH population.

The Primary Care Office (PCO) contracted with a private company for conducting a Dental Provider Survey, with the results primarily used for determining health professional shortage areas. Additional PCO work includes Primary Care and Mental Health Provider surveys in FY 2011.

Montana's Native American mortality rate is higher than that of the Caucasian rate and the overall

rate. The state will continue addressing the state outcome measure assessing the Native American Infant Mortality Rate.

The Director of the Department of Public Health and Human Services has created the Best Beginning Communication Strategic Planning Committee, of which the Maternal and Child Health Coordination (MCHC) and WIC Section Supervisors are key members. The Committee is charged with promoting best beginning services for parents of infants and children 0 to 5 years of age. The Best Beginning services tie in with the MCH toll-free hotline which is a partnership between the FCHB and Healthy MT Kids (formerly known as CHIP).

The Children's Special Health Services (CSHS) Section continues to address how best to solicit information from the CYSHCN parents. Family representatives on the CSHS committee provide input to the FCHB regarding family concerns and needs.

The Governor's Office provides annual Tribal Relations training on issues that impact the Tribal Nations of Montana and the state-tribal relationship. FCHB supervisors and support staff have attended previous trainings and will continue to attend future trainings.

/2012/
The Primary Care Office (PCO) contracted with a private contractor that conducted Primary Care and Mental Healthcare Provider Surveys, with the results primarily used for determining health professional shortage areas. The data is also accessible for other DPHHS programs for grant applications and determining future activities that may require a healthcare professional.

The MCHC and WIC Section Supervisors contributed to several projects undertaken by the Best Beginnings Communication Strategic Planning Committee, which met throughout 2011. A project that is anticipated to be launched in August, 2011 is the Best Beginnings Calendar, a monthly calendar highlighting training opportunities, resources, and other activities for parents of children 0 to 5.

As noted elsewhere, the CSHS Section will be conducting a comprehensive CYSHCN needs assessment by December 2011. This information will be valuable for continuing to assess their needs for access to services such as healthcare and transitioning to adulthood.
The toll free hotline remains a partnership with the Healthy Montna Kids Program.
//2012//

/2013/
The DPHHS Director's Office Best Beginnings Communication Strategic Planning Committee (BBCSPC) continues to meet monthly, with ongoing representation from each DPHHS Division. See the DPHHS organization chart attachment in the Section: Organizational Structure. The Best Beginnings Calendar was initiated in August 2011, with DPHHS staff as the initial target audience.

The BBCSPC's 2012 project is to create a document that includes all the state level services for families of infants and children 0 to 5 years of age. The Best Beginnings Advisory Council's work on creating a statewide plan for a comprehensive early childhood service system was the foundation for the four principal objectives of categorizing DPHHS services: Quality Early Care and Education; Supporting Families; Health and Medical Home Service for Young Children and Families; and Social, Emotional, and Mental Health Needs for Young children and Families. The document will be field tested by MCH BG contractors prior to it being finalized for publication and distribution across the DPHHS, including the Healthy Montana Kids Program which manages the toll free hotline

The CSHS Section CYSHCN Needs Assessment undertaken in December 2011 was used in CSHS' successful application for a State Implementation Grant for Systems of Services for CYSHCN. The needs assessment result is included as an attachment.

The PCO contract with the North Carolina Foundation for Advance Health Programs is aimed at determining what retention activities would persuade MT's 79 ARRA funded NHSC scholars and loan repayers to continue practicing in MT. The retention activities will be evaluated by the PCO and AHEC to determine the most viable for future implementation.

//2013//
An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

The Maternal and Child Health Coordination (MCHC) Section is requesting technical assistance in developing action guides based on best practices for the top five National Performance Measures and for the seven new State Performance Measures. The new State Performance Measures address emerging health issues in Montana and the MCHC section would like to provide MCH contractors with credible action guides to address their performance measure selection and effect positive change in their communities.

The state Fetal, Infant, and Child Mortality Review (FICMR) Coordinator and MCH Epidemiologist request technical assistance on implementing the use of the Child Death Review (CDR) Case Reporting System. Guidance would include assistance with training local FICMR review teams on the use of the CDR.

Montana's Oral Health program requests technical assistance to improve and support the coordination and reporting of dental screenings recommended by Association of State and Territorial Dental Directors. The MCHC would like to provide training and information sessions/workshops for the Oral Health Partners who conduct the dental screenings. The trainings would include information on the recommended procedures for conducting the screenings, reporting the results of the dental screenings and information on dental services available to low-income and at risk children which can be communicated to parents.

Montana's Oral Health program requests technical assistance to support the Access to Baby Child Dentistry (AbCd) program by providing guidance, leadership, technical assistance, and/or educational materials to AbCd providers/coordinators around the state who are faced with the challenge of assisting children aged 0-3 establish a dental home and low-income mothers/pregnant women receive critical dental care.

The MCHC Section requests technical assistance to develop new communication methods in order to relay and obtain relevant feedback and communication to and from MCH partners. The MCHC Section would like to provide web based, quarterly updates regarding MCH services and also provide assistance and guidance in meeting MCH goals. MCHC would also use the new communication methods to receive quarterly report/application materials from MCH contractors.

Montana's immunization rank according to the National Immunization Survey is 50th in the nation. Montana is focused on improving its rate by providing education to the MCH BG and Vaccine For Children contractors. The FCHB, in partnership with MT's Immunization Program, is focused on improving the immunization rate. Dr. Paul A . Offit, an American pediatrician specializing in infectious diseases and an expert on vaccines, immunology, and virology would be a speaker at an immunization conference.

/2012/

The FCHB's technical assistance requests include:

The local FICMR Teams have expressed an interest in adapting the CDR Case Reporting

System whereby if adapted the time previously spent on completing and submitting paper FICMR forms to the state could be spent on prevention activities. If MT were to adapt the CDR Case Reporting System, the local FICMR Teams and the State FICMR Coordinator would need to be trained on the new system.

Attendees at the 2011 Family and Community Health Bureau Conference expressed an interest in having training on home visiting, focusing on the challenges associated with working with families with multiple high risks related needs. MT will be implementing evidence-based home visiting programs with the ACA MIECHV funding opportunity and will continue to support the current Public Health Home Visiting program. Home visiting training would benefit both programs.

//2012//

/2013/

The FCHB's technical assistance requests include:

The local FICMR Teams have expressed an interest in adapting the Michigan Public Health Institute CDR Case Reporting System. MT is working through the process to adapt the Michigan Public Health Institute CDR Case Reporting System. If adapted, FICMR teams will need training on the new system.

If adapted the Local FICMR Coordinators' time previously spent on completing and submitting paper FICMR forms to the State FICMR Coordinator, will be better spent submitting a web based report. At both the state and local level, staff time could be spent on researching and implementing prevention activities. If MT were to adapt the CDR Case Reporting System, the Local and State FICMR Coordinators would need to be trained on the CDR Case Reporting System as this format is different from what is currently in place in MT.

//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	2435138	2410034	2430627		2292158	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2358969	2316886	1816886		2305719	
4. Local MCH Funds *(Line4, Form 2)*	3777376	3847945	3871097		3698449	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1046041	1731666	1666306		1788920	
7. Subtotal	9617524	10306531	9784916		10085246	
8. Other Federal Funds *(Line10, Form 2)*	22531055	4128915	20206929		26178702	
9. Total *(Line11, Form 2)*	32148579	14435446	29991845		36263948	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1595215	1802176	1579159		1891194	
b. Infants < 1 year old	1255402	1134302	1244907		1220714	
c. Children 1 to 22 years old	2717490	2915252	3135787		3231132	
d. Children with	1820878	2019015	2168843		1935921	

Special Healthcare Needs						
e. Others	1798819	2043358	1250392		1587760	
f. Administration	429720	392428	405828		218525	
g. SUBTOTAL	9617524	10306531	9784916		10085246	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		97260		82192	
c. CISS	132000		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	130000		130000		130000	
g. WIC	17012511		14272338		16878855	
h. AIDS	1260714		1260714		1316462	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
ACA-Development ID	0		0		3263022	
ACA-Home Visiting SD	0		0		1000000	
Immunization	741049		0		250302	
Oral Health	0		0		399076	
Title X FP	2474866		2454077		2365154	
UNHBS	299000		273447		273403	
WIC Farmers Market	57353		57353		59782	
WIC Peer Counseling	203849		104715		160454	
Affordable Care Act	0		663933		0	
Immunization	0		540294		0	
Oral Health	0		226798		0	
PHBG FP	126000		126000		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	4004151	4183834	3548140		3947062	
II. Enabling Services	2304937	2629504	2510896		2428210	
III. Population-Based Services	1994812	2054776	2287463		2335654	
IV. Infrastructure Building Services	1313624	1438417	1438417		1374320	
V. Federal-State Title V Block Grant Partnership	9617524	10306531	9784916		10085246	

Total						

A. Expenditures

The Family and Community Health Bureau (FCHB) Financial Specialist and the Public Health and Safety Division's Fiscal Bureau Analyst maintain the budget documentation for Montana's Maternal Child Health Block Grants, including assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant 2009 Annual Report and 2011 Application reflect the importance of local partners for providing MCH services to the population. For FY 2011, approximately 41% of the MCHBG will be distributed through contracts with 55 of the state's 56 city-county health departments.

Montana, along with most other states, is not initiating new programs at this point, instead carefully monitoring state funding and working to maintain existing services. The FCHB will continue to seek additional financial resources, as well as develop new and maintain existing relationships with public and private partners for the intent of increasing the services to Montana's maternal child health population.

The following is a summary of Forms 3, 4, and 5.

Form 3:

Montana's total expenditures to support MCH services has increased by about $2 million over the last five years. Local and state funds and program income have increased, especially since 2007, while federal support has decreased. Increases are attributable to ongoing commitment of local funds to MCH services, state funding to support new and expanded MCH programs, such as a newborn screening follow up program and contraceptive support, and active pursuit of billing funding to support clinics for children with special health care needs. See attached table and chart for Form 3.

Form 4:

Montana's expenditures by population group differed only slightly from 2008 to 2009. An increase of about $150,000 in administrative costs is attributable to cost allocation increases at the state agency as well as to slight increases in administrative costs at the local level.

Form 5

Expenditures for direct health care, enabling, population-based, and infrastructure building services vary from year to year, due in great part to the local MCH contractor's yearly expenditure reports.

/2012/

Maternal and Child Health Coordination (MCHC) Supervisor is responsible for the MCH Block Grant. The MCHC Supervisor works with the FCHB Financial Specialist and the Public Health and Safety Division's Fiscal Bureau Analyst, who are responsible for maintaining the budget documentation for the MCH Block Grant. They are also responsible for assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant 2010 Annual Report and 2012 Application reflect the importance of local partners for providing MCH services to the population. For FY 2012, approximately 41% of the MCHBG will be distributed through contracts with 53 of the state's 56 county health departments.

The ACA MIECHV funding opportunity provided Montana with the capacity to implement, at the local level, evidence based home visiting model (s). At the time of the MCH Block Grant submission, one county health department, working in collaboration with the tribal health department, will implement Parents As Teacher pending the receipt that the Updated State Plan Notice of Grant Award. It is anticipated that additional home visiting models will be implemented in FY 2012. The state also applied for a ACA MIECHV Development Grant for the purposes of addressing the infrastructure capacity of up to 25 communities identified through the ACA MIECHV Needs Assessment as at risk communities.

The FCHB will continue to seek additional financial resources, as well as develop new and maintain existing relationships with public and private partners for the intent of increasing the services to Montana's maternal child health population. This is due in part to the 2011 Legislative session approved the Public Health and Safety Division 2013 biennial budget request at approximately $3.1 million or 2.4% less when compared to the 2011 biennium. For more information go to: http://leg.mt.gov/css/fiscal/reports/2011-session.asp#ba2013. The budget decrease had minimal impact on the FCHB as it is primarily funded through Federal grant opportunities; however, other agencies that also provide services to the MCH population were less fortunate.
The following is a summary of Forms 3, 4, and 5.

Form 3:
This reflects the decrease in the federal and state general and special revenue funding support. There was an increase for local MCH funding support.

Form 4:
There was a slight increase in the overall Federal-State MCH grant partnership due in part to a decrease in the administrative costs, as noted in the budget report and in the Section titled Other MCH Capacity and the one time only increase for a CSHS special project in FY 2012. The other Federal fund amount reflects the overall decrease in federal funding.

Form 5

Expenditures for direct health care, enabling, population-based, and infrastructure building services continue to vary from year to year, due in great part to the local MCH contractor's yearly expenditure reports.

//2012//

/2013/

Oversight of MT's Title V/MCH BG remains unchanged from 2012. The MCHC Supervisor and the FCHB Financial Specialist ensure proper expenditure of the funds. The PHSD Financial Analyst ensures that the FSRs are accurately completed.

MT was granted an ACA MIECHV Development Grant for FY 2012 and 2013. The grant is providing financial assistance to MT's seven tribes and 22 communities identified through the ACA MIECHV Needs Assessment as at risk communities. The communities are charged with developing an Early Childhood Coalition and completing a community assessment to aid them in selecting one of the evidence based home visiting models that best meets the needs of their community.

The CSHS was awarded a State Implementation Grant for Systems of Services for CYSHCN. This grant will enable the hiring of a program coordinator who will oversee assessment, education/training and how to better partner to coordinate care for CYSHCN.

The FCHB has limited programs supported with state general funds. In SFY 2013, it is

anticipated that the Public Health Home Visiting (PHHV) Program 14 county health and one tribal health department programs' financial level of support will be the same.

Form 3:
The two aforementioned grants increased MT's federal funds line item. CSHS continues with their efforts to increase program income for the services provided at their regional pediatric clinics.

Form 4:
As noted on Form 4, the federal-state partnership for the MCH BG population categories remained essentially unchanged from 2012, except for administrative costs which continue to decline. The additional MIECHV and CSHS grants substantially increased MT's overall total for federal funding assistance.

Form 5

Expenditures for direct health care, enabling, population-based, and infrastructure building services continue to vary from year to year, due in great part to the local MCH contractor's yearly expenditure reports.

//2013//

B. Budget

Montana's proposed Maternal and Child Health (MCH) Block Grant budget for FFY 2011, as reflected on Form 2, includes the following budget items:

Primary and Preventive Services for Children: This budget item includes the anticipated amount to be spent for infants, children and their families. At the state level, this line item reflects the Maternal Child Health Coordination Section and county level MCH contractors who are responsible for providing these services. The FFY 2011 amount is $809,683.

Children with Special Health Care Needs: This budget items includes the Children with Special Health Services Section's budget of $730,541 plus $108,125 from the county level MCH contractors. The FFY 2011 amount is $838,666.

Title V Administrative Costs: This budget item includes the state indirect total of $174,087, plus an anticipated amount of $57,322 from the county level MCH contractors. They are allowed to use up to 10% of their award for administrative costs per the MCH Administrative Rule 37.57.1001. The FFY 2011 amount is $231,409.

The unobligated FY 2011 balance is $0. Montana continues to budget and expend to the level of the annual award.

The State MCH matching fund amount for FY 2011 is $2,358,969 which includes state general funds for the Public Health Home Visiting/ Montana's Initiative for the Abatement of Mortality in Infants Program, the newborn screening program, and family planning programs. The local county level MCH contractors are anticipated to overmatch their allocated MCH Block Grant fund amount. The FFY 2011 local county level MCH amount is $3,777,376.

The MCH Program income for FY 2011 is $1,046,041.

Montana's FY 2011 Maintenance of Effort remains at $485,480, resulting in the Federal-State Title V Block Grant Partnership as $9,617,524. Montana also receives additional federal grant funds, i.e. SSDI, CISS, Title X, Immunization, Universal Newborn Hearing Screening, which total

$3,902,117.

For FY 2011, Montana's state MCH budget total is: $32,148,579.

/2012/
The proposed 2012 MCH Block Grant budget reflects the anticipated decrease in the state's federal allocation. If it appears that additional funds will be awarded, the expended budget will reflect the increased amount.

Primary and Preventive Services for Children: There is a slight decrease in the anticipated amount for this line item attributable to a decrease in the MCH BG allocation. These funds benefit infants, children and their families as served by the county health department contractors and for MCHC Section staff members.

Children with Special Health Care Needs: As noted on Form 2, this line item is approximately eight percent more than FY 2011. For FY 2012, CSHS will receive a onetime only increase for a Cystic Fibrosis special project.

Title V Administrative Costs: The county health department contractors are allowed to expend up to 10% of their MCH BG amount for administrative costs, which for FY 2012 are projected to be $70,100. The state administrative costs ($155,195) reflect an analysis of decreasing from 13.5 to 10.1 FCHB/FTEs being supported with 2012 MCH BG funding.

The unobligated FY 2012 balance is $0. Montana continues to budget and expend to the level of the annual award.

The State MCH matching fund amount for FY 2012 is less than FY 2011. The $1,816,886 reflects the loss of state funding for the Women and Men's Health Section's family planning programs and state level support for the MCHC Section. The match includes state general funds for the Public Health Home Visiting/ Montana's Initiative for the Abatement of Mortality in Infants Program and the newborn screening program. The local county level MCH contractors are anticipated to overmatch their allocated 2012 MCH Block Grant fund amount with the projected amount at $3,871,097.

The MCH Program income for FY 2012 is $1,666,306 which reflects billing income from a new CSHS clinic and either improved Medicaid billing or Medicaid billing reporting by county health departments.

Montana's FY 2012 Maintenance of Effort remains at $485,480, resulting in the Federal-State Title V Block Grant Partnership as $9,784,916. Montana also receives additional federal grant funds, i.e. ACA MIECHV, SSDI, Title X, Immunization, Universal Newborn Hearing Screening, which total $20,206,929.

For FY 2012, Montana's state MCH budget total is: $29,991,845.

//2012//

/2013/

The proposed 2013 MCH Block Grant budget reflects the anticipated decrease in the state's federal allocation. If it appears that additional funds will be awarded, the expended budget will reflect the increased amount.

Primary and Preventive Services for Children: There is a slight increase in the anticipated amount for this line item attributable to an increase in ACA funding allocated to Montana's County Health Departments . These funds benefit infants, children and their families as

served by the county health department contractors and for MCHC Section staff members. The FY 2013 budgeted amount is $842,475.

Children with Special Health Care Needs: There is a decrease to this line item as compared to FY 2012 on Form 2 where CSHS received a onetime only increase for Cystic Fibrosis special project. For FY 2013, CSHS will receive $792,131.

Title V Administrative Costs: The county health department contractors are allowed to expend up to 10% of their MCH BG amount for administrative costs, which for FY 2013 are projected to be $76,885. The state administrative costs increased $115 from the 2012 to 2013 projection, $155,195 versus $155,310. $218,525

The unobligated FY 2013 balance is $0. Montana continues to budget and expend to the level of the annual award.

The State MCH matching fund amount for FY 2013 is more than FY 2012. The $2,305,719 reflects the additional state funding for the Women and Men's Health Section's family planning programs and state level support for the MCHC Section's administration of the Public Health Home Visiting Programs. The match includes state general funds for the Public Health Home Visiting/ Montana's Initiative for the Abatement of Mortality in Infants Program and the newborn screening program. The local county level MCH contractors are anticipated to overmatch their allocated 2013 MCH Block Grant fund amount with the projected amount at $3,698,449.

The MCH Program income for FY 2013 is $1,788,920 which reflects billing income from a new CSHS clinic and either improved Medicaid billing or Medicaid billing reporting by county health departments.

Montana's FY 2013 Maintenance of Effort remains at $485,480, resulting in the Federal-State Title V Block Grant Partnership as $10,085,246. Montana also receives additional federal grant funds, i.e. ACA MIECHV, SSDI, Title X, Immunization, Universal Newborn Hearing Screening, which total $22,915,680.

For FY 2013, Montana's state MCH budget total is: $36,263,948.

//2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.